

S-455

BALTIMORE CITY HEALTH DEPARTMENT

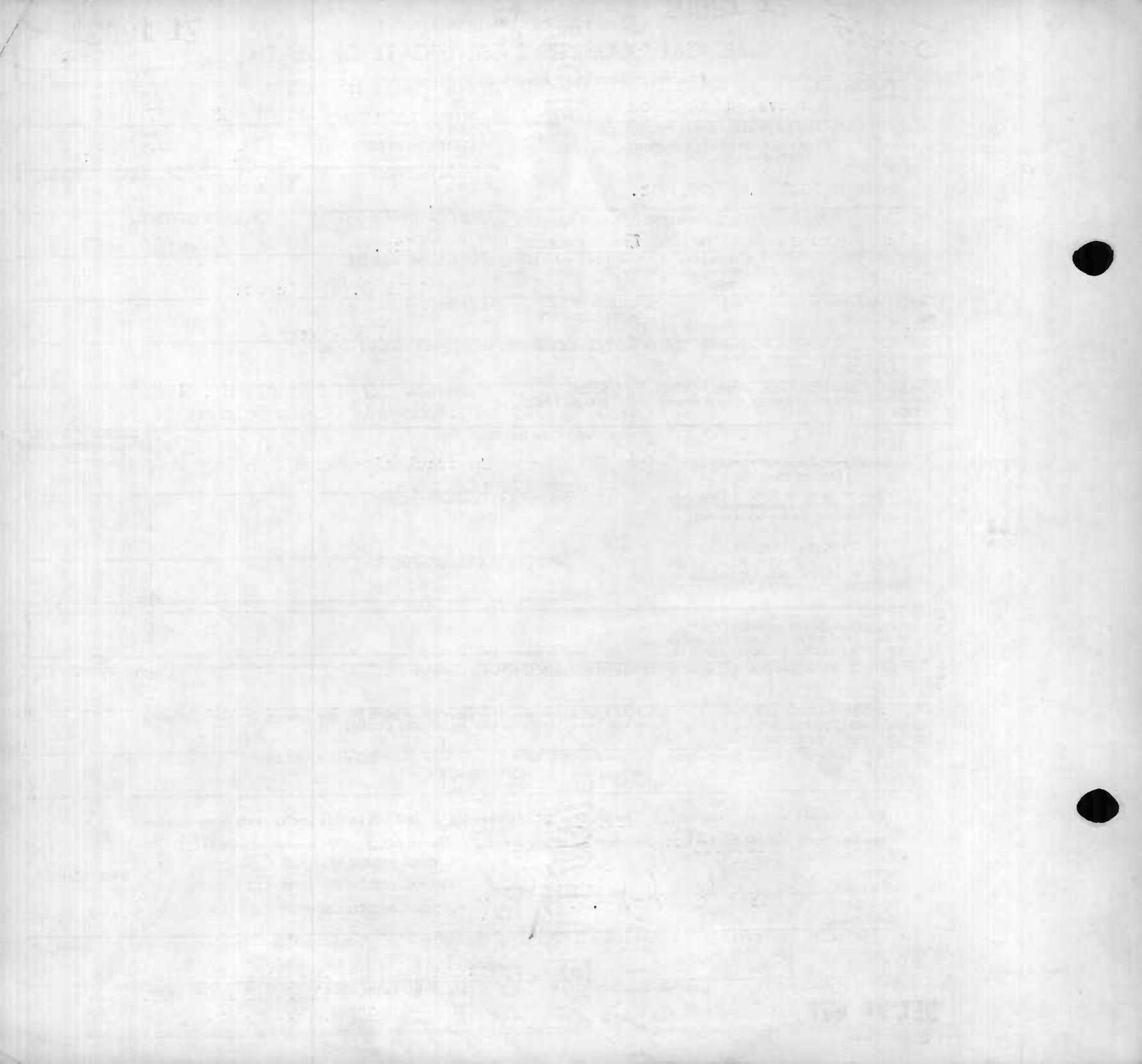
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12001

BIRTH NO.

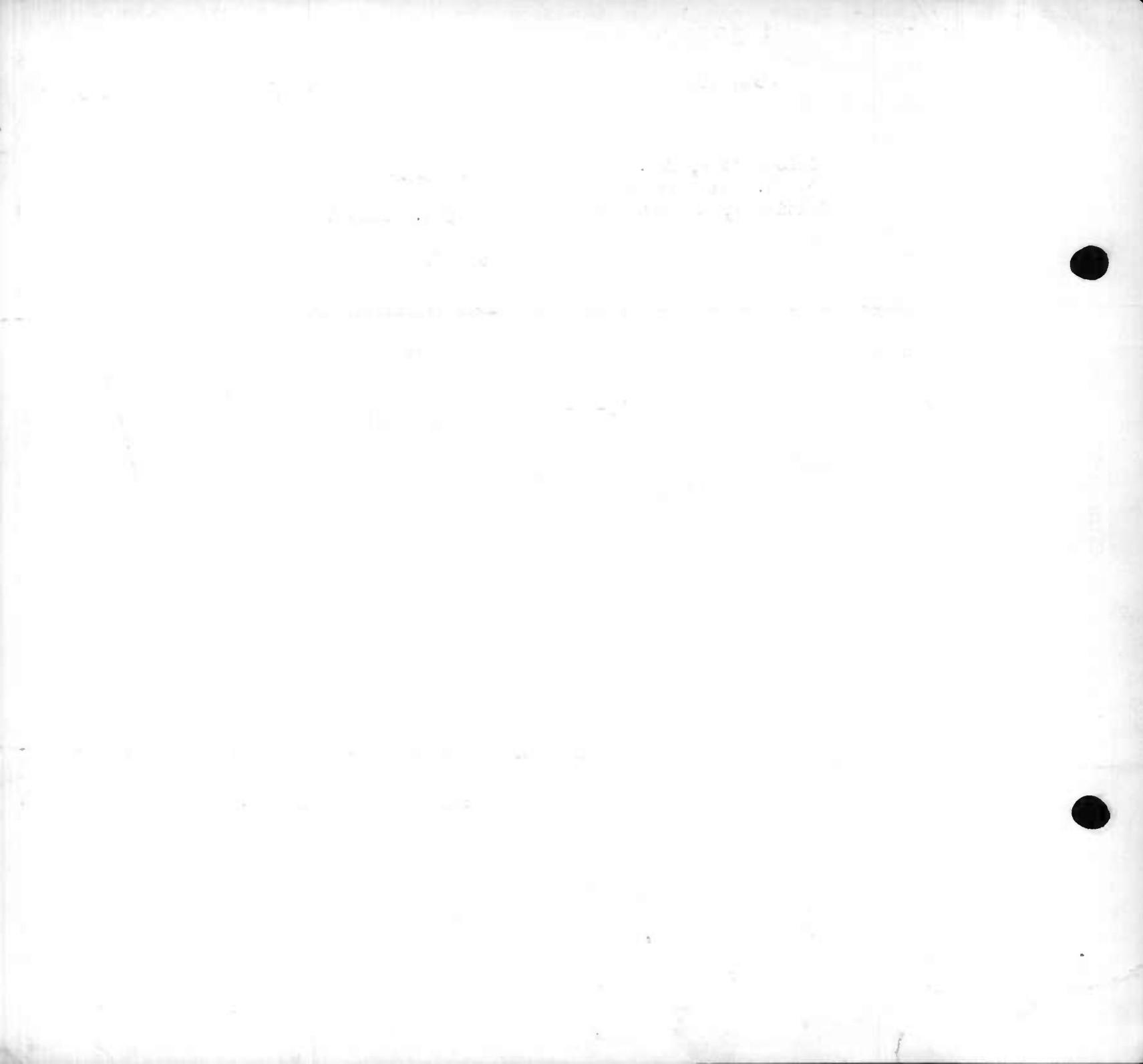
1. NAME OF DECEASED (Type or Print)		M		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Doy 23	Year 71	Hour M.
Cleveland Solomon				Estimated <input type="checkbox"/>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		1223 E. Biddle St.		3. DATE PRONOUNCED DEAD	Month 12	Day 23	Year 71	Hour 1:15 P.M.
100								
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 3-15-29		10. AGE (In years lost birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1223 E. Biddle St.				
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Cleveland Solomon			14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mrs. Margarit Curtis Solomon						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 250-30-8129	18. INFORMANT 1223 E. Biddle St. ADDRESS Mrs. Margarit Curtis Solomon			19. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. MEDICAL CERTIFICATION		20B. DATE OF OPERATION			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type)						
Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-1971		24C. NAME OF CEMETERY or CREMATORIAL Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1971		25B. NAME OF REGISTRAR Robert E. Faber, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213				
				Marshall W. Jones, Jr.				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-435		71 12002	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12002
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/20/71		7:15 A.M.	
1. NAME OF DECEASED (Type or Print) <b>John HILTON</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>90</b>  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE & COUNTY <b>Maryland</b>  C. CITY OR TOWN <b>Baltimore</b>  D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>2101</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/07</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rockville, Maryland</b>	
13. FATHER'S NAME <b>unk.</b>		14. MOTHER'S MAIDEN NAME <b>unk.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-1683</b>		17. INFORMANT <b>Henry E. Prentiss</b> 8452 Piney Branch Court <del>Charter exhibition</del> Silver Springs, Md. 20901	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b>		ADDRESS  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C.V. Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>C.V.A - Right Hemiparesis</b>		1 mo.	
MEDICAL CERTIFICATION  19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 3 1971</b> to <b>December 20 1971</b> that (I) (we) last saw the deceased alive on <b>Dec 18 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <i>Joseph S. Blum Jr.</i>		23B. DATE SIGNED  <b>12/20/71</b>			
23C. PHYSICIAN'S NAME (Type)  <b>JOSEPH S. BLUM MD</b>		23D. ADDRESS  <b>1115 N. CALVERT ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Tauber, M.D.</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave.</b> ADDRESS <b>Marshall W. Jones, Jr.</b>	
VS 150-REV. 1/1/68					



445291 12003

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12003

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Roosevelt Holmes

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION

34 Bon Secours Hospital

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 9. DATE OF BIRTH

1/16/07

10. AGE (in years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

## 14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

## 18. INFORMANT

2. DATE Known  Month Day Year  
OF DEATH Estimated  12 28 71 11:30A. M.3. DATE Month Day Year  
PRONOUNCED DEAD 12 28 71 11:30A. M.

## 5. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

## A. STATE

Maryland

## B. COUNTY

2001

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES  NO 

## E. STREET AND NUMBER

1912 W. Fayette Street

## 13. FATHER'S NAME

Robert L. Taylor  
1912 W. Fayette Street  
Baltimore, Md.

## ADDRESS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## 19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

## MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

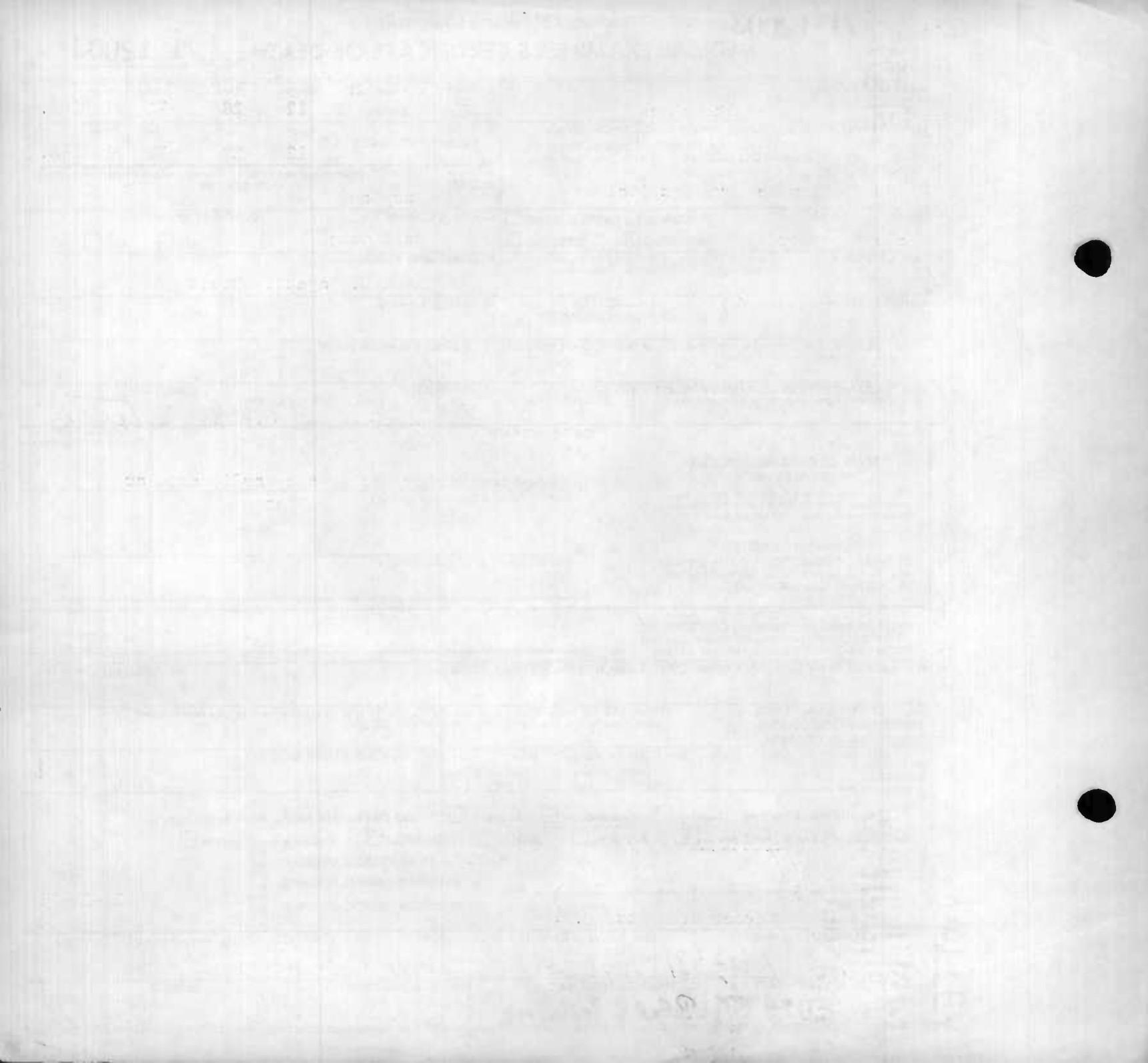
## 21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

## 22F. HOW DID INJURY OCCUR?

VS 151-REV. 1/1/68



H-620

71 12004

BALTIMORE CITY HEALTH DEPARTMENT

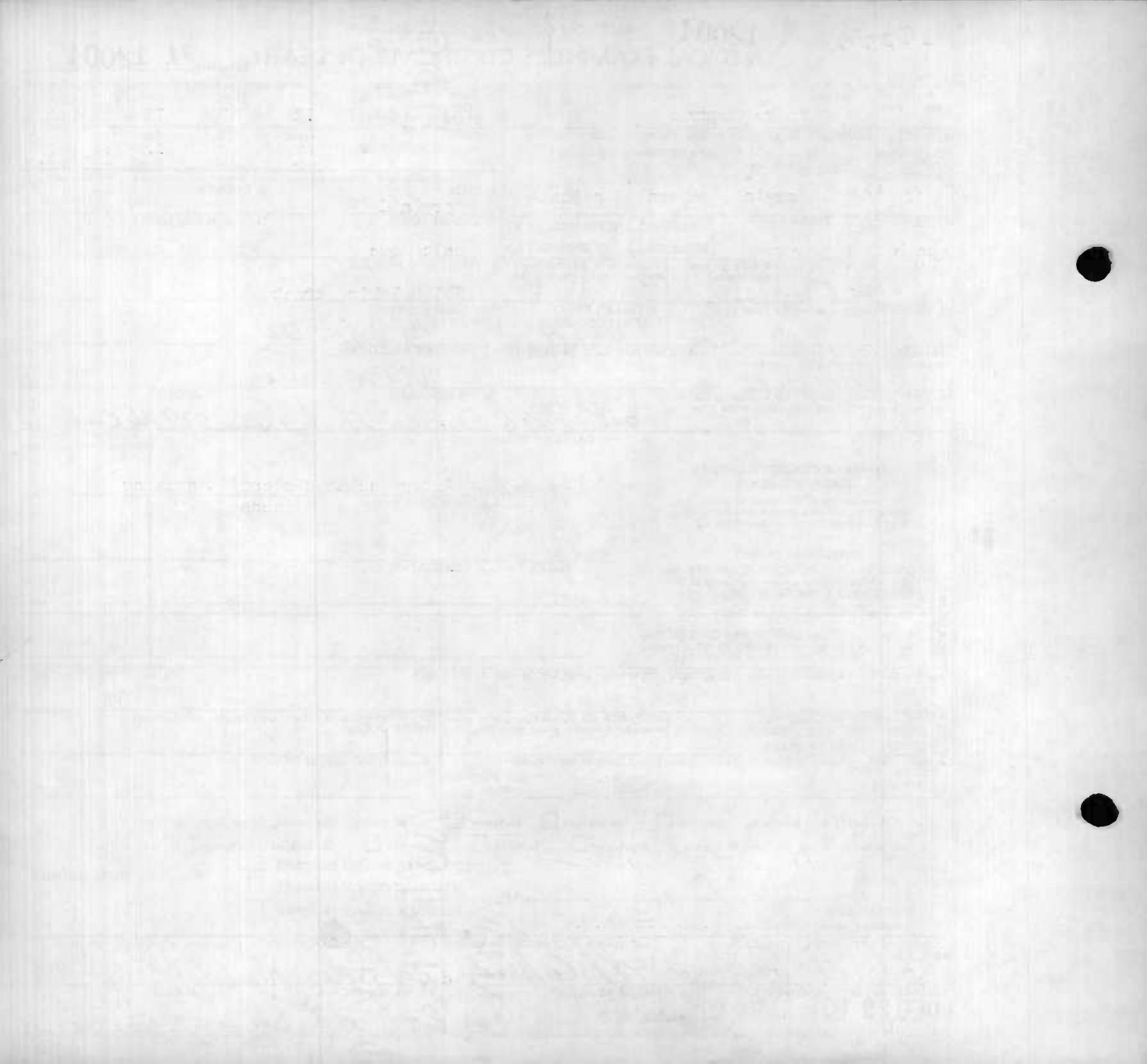
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12004

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Andrew Harris		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month Estimated <input type="checkbox"/> 12	Doy 27	Year 71	Hour 11:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	Month 12	Doy 27	Year 71	Hour 11:30A. M.	
48		Maryland General Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 1702			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH 10-14-06		10. AGE (In years lost birthday) 65	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 501 Dolphin Street				
11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			17. SOCIAL SECURITY NO. 218-05-3898	18. INFORMANT Dorien Hudgins	ADDRESS 501 McCulloh St.
19. MEDICAL CERTIFICATION		CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: disease							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C)							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) Yes		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT m. WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. ACTUAL SIGNATURE EXAMINER'S NAME (Type)		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12-28-71		
24A. BURIAL-CREMATION, REMOVED (Specify)		24B. DATE Burial 12-30-71		24C. NAME of CEMETERY or CREMATORIAL Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) Anne Arundel County, Md.			(State)
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Miller, Jr.		25C. FUNERAL DIRECTOR Gordon B. Scruggs		ADDRESS 412 E. Preston St.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-542 71 12005

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12005

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BORIS SAMUELS

2. DATE AND HOUR OF DEATH

DECEMBER 27, 1971

6

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4024 GLEN AVENUE

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

4024 GLEN AVENUE

D. INSIDE CITY LIMITS?

YES  NO

2720

5. SEX

6. RACE

MALE

WHITE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

B. DATE OF BIRTH

SEPT. 15, 1888

9. AGE (In years  
lost birthday)

83

If Under 1 Yr.  
Months: Days

If Under 24 Hrs.  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SELF EMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

GROCERY STORE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ZOLMAN MOISHE SAMUELS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-32-2732

17. INFORMANT

MRS. LIBBY SAMUELS, 4024 GLEN AVENUE, #21215

ADDRESS

CAUSE OF DEATH

*Arteriosclerotic Heart Disease*

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

17 years

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

*Diabetes Mellitus*

(B) DUE TO, OR AS A CONSEQUENCE OF:

*na*

(C)

*na*

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED  
While At  Not While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from  
that (I) (we) last saw the deceased alive on

*Dec 27 Jan 28 1954 to Dec 27 1971*

and that in (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Manuel Levin M.D.*

DEGREE

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

*12/27/71*

23C. PHYSICIAN'S  
NAME (Type)

MANUEL LEVIN

23D. ADDRESS

6101 PARK HEIGHTS AVENUE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-27-71

24C. NAME OF CEMETERY or CREMATORIUM

AITZ CHAIM

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

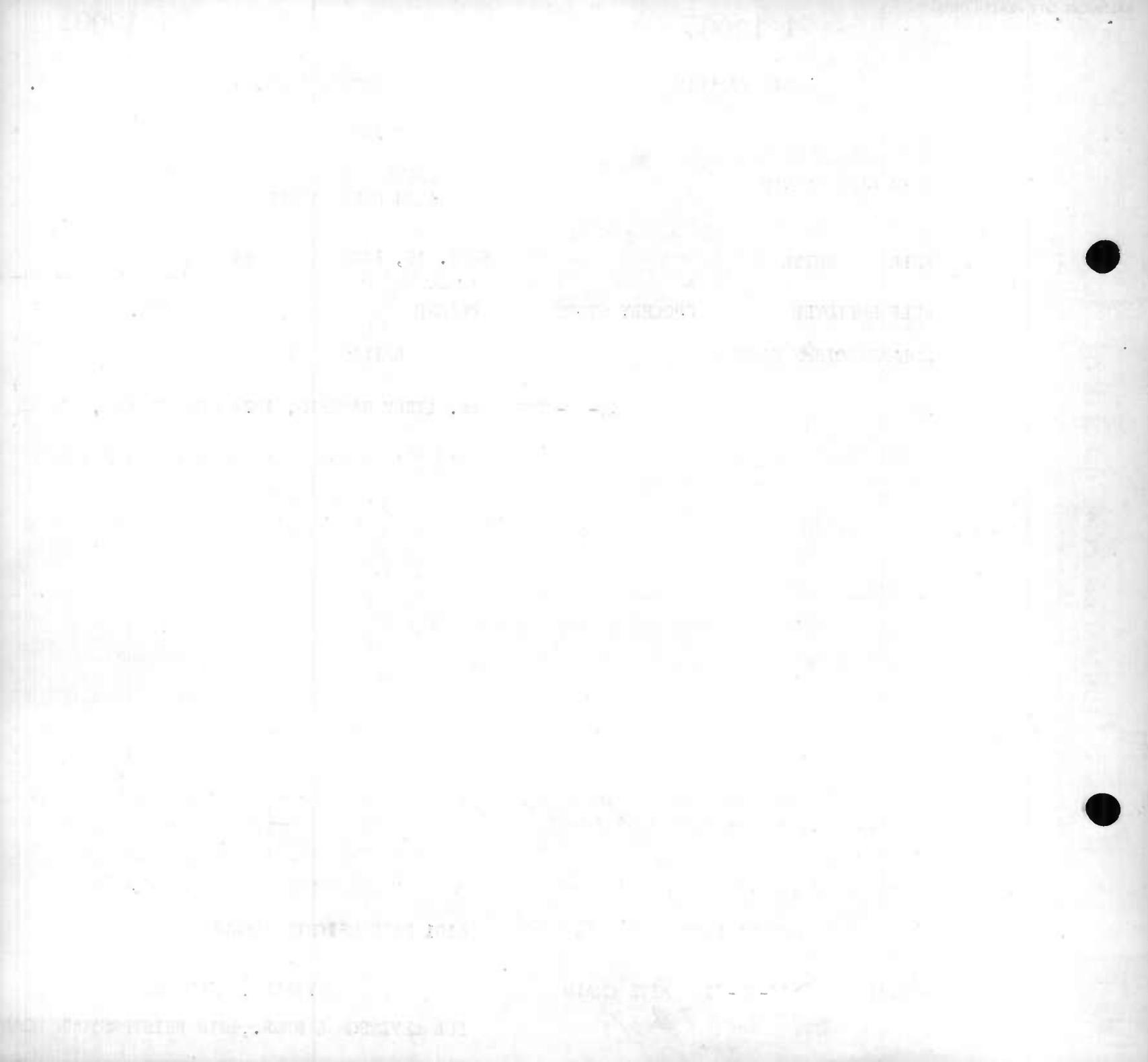
DEC 29 1971 Robert E. Salley, M.D.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420 71 12006

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

X REG. NO.

71 12006

BIRTH NO.

I. NAME OF DECEASED  
(Type or Print)

WOLK, SARAH

2. DATE AND HOUR OF DEATH

12 - 26 - 71

8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

New York

C. CITY OR TOWN

Brooklyn

E. STREET AND NUMBER

1379 54<sup>th</sup> Street

D. INSIDE CITY LIMITS?

YES

NO

V29

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

3 | 20 | 1900

9. AGE (in years  
last birthday)

71

If Under 1 Yr.  
Months

Days

If Under 24 Hrs.  
Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

13. FATHER'S NAME

Joseph Wold

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

078-20-3560

CAUSE OF DEATH

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Basha Donosky

ADDRESS

Rabbi Joseph Wold 5440 Nelson Ave

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Arteriosclerotic HT. Disease 4 months

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Smitely

1 year

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

Diabetes Mellitus

10 years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED  
While At Work  Not While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (This hospital) attended the deceased from \_\_\_\_\_ November 19 71 to Dec 26, 19 71  
that (I) (we) last saw the deceased alive on Dec. 26, 19 71 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marvin Goldstein, M.D.

DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED  
12 26 71

23C. PHYSICIAN'S  
NAME (Type)

DR MARVIN GOLDSTEIN

DEGREE

8205 ANITA ROAD

23D. ADDRESS

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

12/27/71

24C. NAME OF CEMETERY or CREMATORIUM

King Solomon

24D. LOCATION  
(City, town, or county)

Clifton

(State)

New Jersey

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

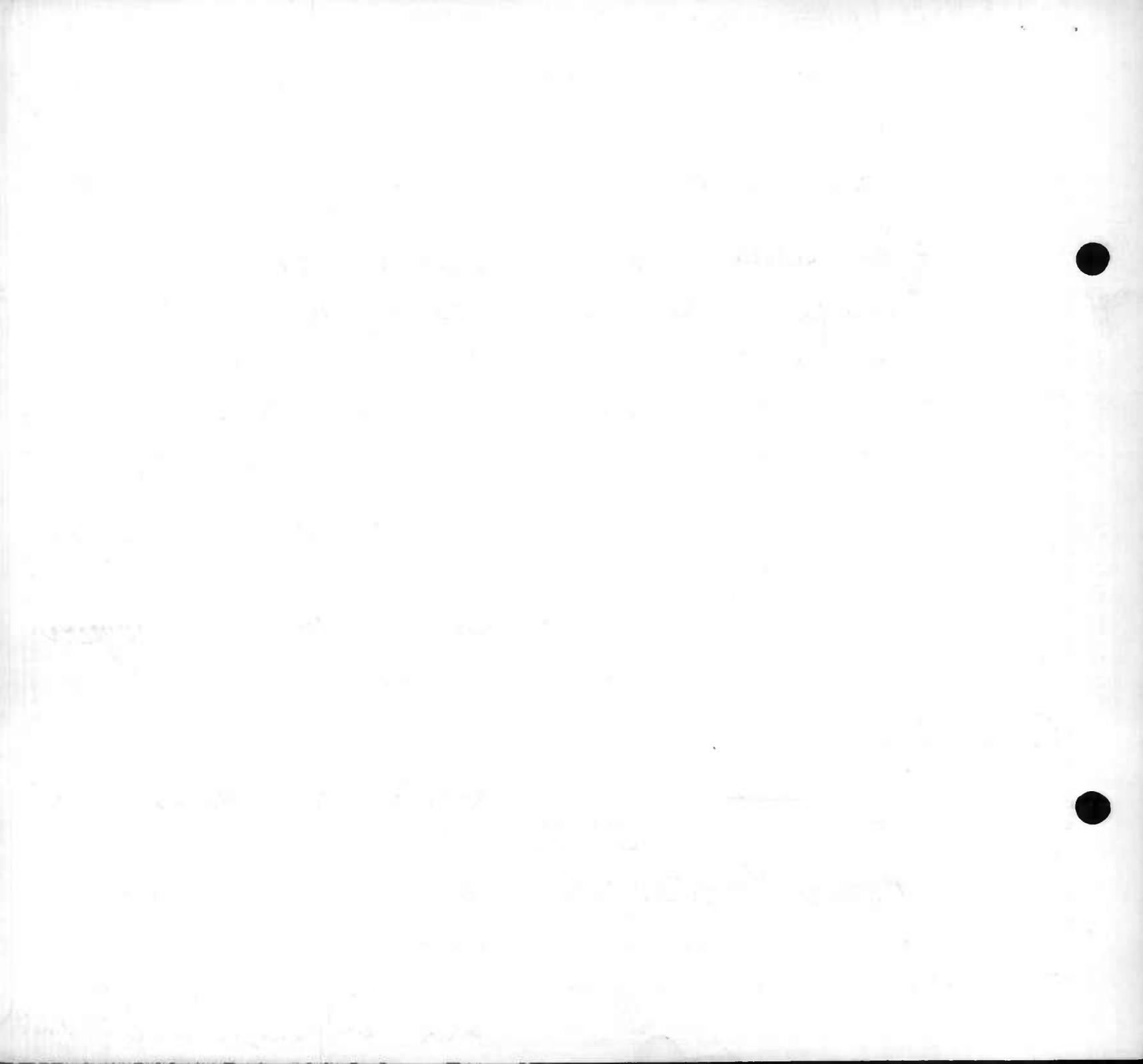
Robert E. Johnson

25C. FUNERAL DIRECTOR

Gold Levinson & Sons, Inc. 6010 Restaurants Rd

ADDRESS

RD



B-600 71 12007

## CERTIFICATE OF DEATH

71 12007

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA BAER

2. DATE AND HOUR OF DEATH

DEC 25, 1971

7 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

39

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived; II institution; residence before admission)  
A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

1512

YES  NO 

E. STREET AND NUMBER

3437 Park Heights Avenue

5. SEX

6. RACE

Female

White

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

At Home

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)

75

If Under 1 Yr.  
Months Days Hours  
Min.

13. FATHER'S NAME

Wolf Baer

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-01-3001A

17. INFORMANT

Miss Rose Baer 3437 Park Heights Avenue

ADDRESS

18. 4109 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION first.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarct

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

minute

(B) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerosis

years

(C) \_\_\_\_\_

## MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At  Not While  
At Work 22. I certify that (I) (this hospital) attended the deceased from  
that (I) (we) last saw the deceased alive on Dec. 21, 1971, and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Donald I. Miller

DEGREE

Attending  
Phys.Med.  
DirectorStaff  
Phys. 

23B. DATE SIGNED

Dec. 26-71

23C. PHYSICIAN'S  
NAME (Type)

Donald I. Miller

DEGREE

23D. ADDRESS

S. Sinai Hospital - Bldg. A

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORIUM

24D. LOCATION

(City, town, or county)

(State)

Burial 12/26/1971 Beth Jacob Anshe Veshear Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 29 1971 Robert E. Leiby, M.D.

Sol Levinson &amp; Bros. 6010 Reisterstown Road



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-550		71 12008	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12008
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <u>12/25/71</u>			
Harold E Hinman M.D.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>NEW YORK CITY N.Y.</u> B. COUNTY <u>V29</u>			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>WARSAW</u> E. STREET AND NUMBER <u>73 WEST COURT STREET</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/10/04</u>	9. AGE (in years lost birthday) <u>61</u>	If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HINMAN, EDWARD J.</u>		14. MOTHER'S MAIDEN NAME <u>ISAAC. EDITH</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>445 30 7623</u>		17. INFORMANT <u>Edward Hinman - M.D.</u>	
18. <u>41231</u>		CAUSE OF DEATH  <u>Circulatory Collapse</u>		ADDRESS <u>5218 Windmill Ln.</u> <u>COLUMBIA</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ostheno, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:  <u>Pulmonary Embolus</u>		<u>30 minutes</u>	
(C) <u>Venous Thrombosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(D) <u>Atherosclerotic Heart Disease</u>			
19A. DATE OF OPERATION <u>12/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ventricular Thrombus</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/19/71</u> to <u>12/25/71</u> that (I) (we) last saw the deceased alive on <u>12/25/71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William J. Anderson M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Johns Hopkins Hosp Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>12-27-71</u>		24C. NAME OF CEMETERY OR CREMATORIUM <u>Loudon Park Crematory</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>Jubel L. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>W. Cook - Brooks Dawson Inc.</u>	
				ADDRESS <u>Dawson, Md.</u>	



W-600 71 12009

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12009

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Marie  
EFFIE WARE2. DATE Known  Month Doy Year Hour  
OF DEATH Estimated 

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31 Baltimore City Hospital

3. DATE Month Doy Year Hour  
PRONOUNCED DEAD 12 26 1971 9:50 a.m.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY 2605

6. SEX

female

7. RACE

white

8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED C. CITY OR TOWN  
Balto. D. INSIDE CITY LIMITS?  
YES  NO 

M.

9. DATE OF BIRTH

Sept. 3, 1935

10. AGE (In years  
lost birthday) 36 44  
If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF  
WHAT COUNTRY? USAE. STREET AND NUMBER  
4921 Eastern Ave.14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)  
---14B. KIND OF BUSINESS OR INDUSTRY  
---15. MOTHER'S MAIDEN NAME  
Bell Williams16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no none

17. SOCIAL SECURITY NO. yes

18. INFORMANT  
Mr. Wilbur Ware 4921 Eastern Ave.

ADDRESS

19. CAUSE OF DEATH  
Carbon monoxide poisoningAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A). Acute alcoholic intoxication

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)  
home22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12-26-71 a.m.22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 22F. HOW DID INJURY OCCUR?  
House fire.23. I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinionresulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-27-71

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

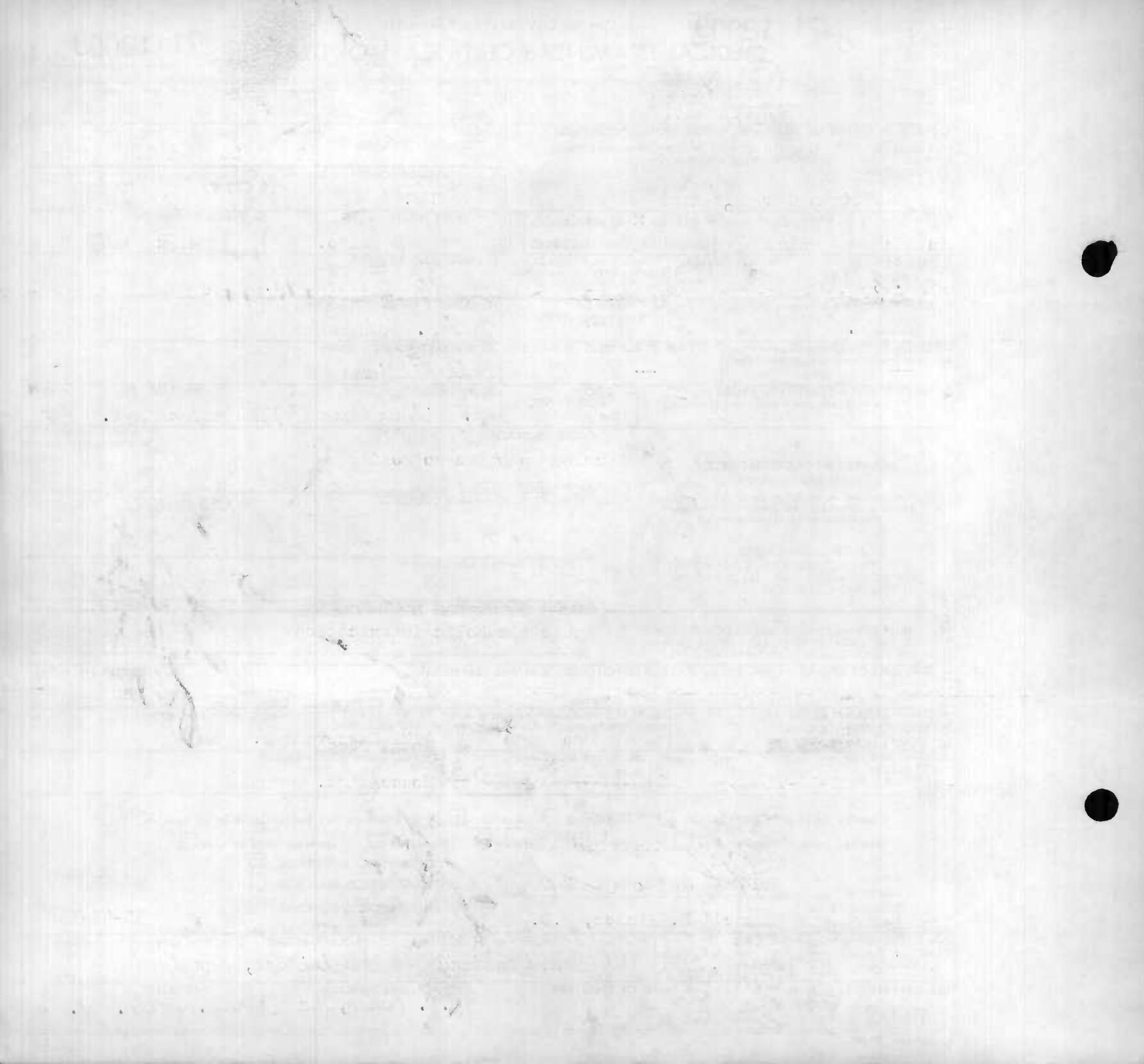
Russell S. Fisher, M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify) Burial 24B. DATE Dec 28, 1971 24C. NAME OF CEMETERY or CREMATORIUM Oak Lawn Cemetery24D. LOCATION (City, town, or county) (State)  
Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 25B. NAME OF REGISTRAR Robert S. Fisher, M.D.

25C. FUNERAL DIRECTOR J.A. Moran, Inc 3000 E. Balto. St.

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

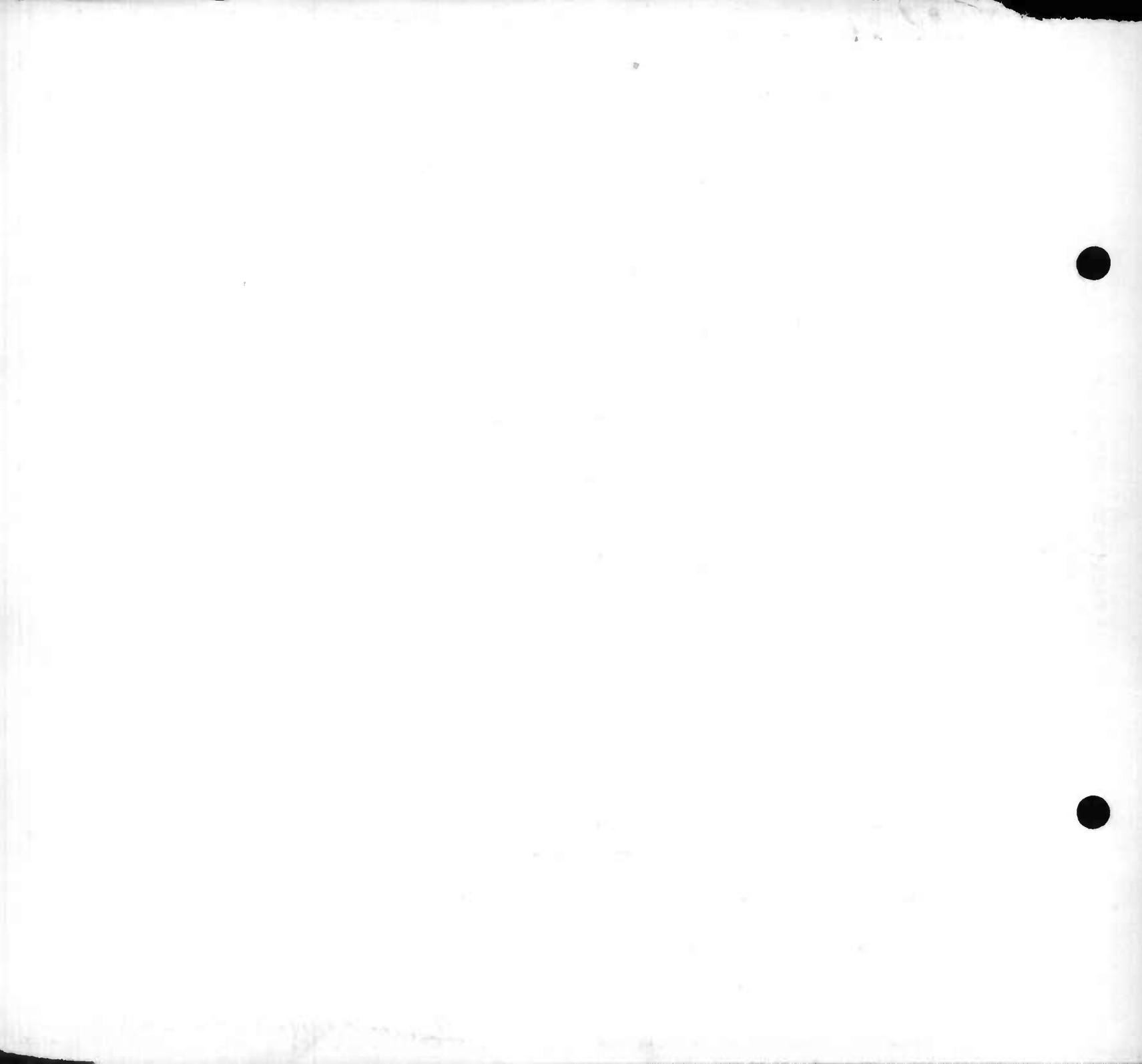
S-320		71 12010		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12010	
BIRTH NO.				2. DATE AND HOUR OF DEATH 12-26-'71		2 30 a.m.			
1. NAME OF DECEASED (Type or Print) <b>Irvin L. Sheetz</b>				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Keswick Home - 700 W 40th St.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore, Md.		1307	
91				C. CITY OR TOWN Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 700 W. 40th St.		F. ZIP CODE 21211			
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-04		9. AGE (in years last birthday) 60 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Sheetz				14. MOTHER'S MAIDEN NAME Adeline King					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XX		16. SOCIAL SECURITY NO. 220-54-2653		17. INFORMANT Keswick Records, 700 W. 40th. St.		ADDRESS			
18. <i>4339</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized arteriosclerosis</i>		<i>2 yrs</i>			
				(C)  <i>Congenital mental retardation</i>					
19. MEDICAL CERTIFICATION		20A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. AUTOPSY? (Yes or No)		20D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Harold P. Biehl MD</i>		23B. DATE SIGNED 12/26/71							
23C. PHYSICIAN'S NAME (Type) <b>HAROLD P. BIEHL M.D.</b>		23D. ADDRESS 700 W 40th St							
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/71		24C. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		24D. LOCATION (City, town, or county) Williamsport-Washington-Md.			
25A. DATE REC'D. BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Leaf		25C. FUNERAL DIRECTOR Albert L. Leaf Bx. 348 Williamsport, Md.		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-624		71 12011	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12011
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-26-71 8:45 A.M.			
1. NAME OF DECEASED (Type or Print) <b>HILDA K. MARSHALL</b>		4. USUAL RESIDENCE (Where deceased lived. II institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1102</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>GOOD SAMARITAN HOSPITAL</b> <b>45</b>		C. CITY OR TOWN <b>Baltimore</b> E. STREET AND NUMBER <b>1001 N. Charles St</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>02-23-12</b>		9. AGE (in years lost birthday) <b>59</b>		11. Under 1 Yr. Months <b>0</b> 12. Under 24 Hrs. Days <b>0</b> 13. Under 24 Hrs. Hours <b>0</b> 14. Under 24 Hrs. Min. <b>0</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>DURWARD BOY HARDING</b>		14. MOTHER'S MAIDEN NAME <b>-</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-07-4526</b>		17. INFORMANT <b>Harold, son</b> ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>UREmia</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <b>Scleroderma of kidney</b> DUE TO, OR AS A CONSEQUENCE OF:		(C) <b>Scleroderma (Prog. Systemic Sclerosis)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2 Nov</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>X Yes</b>	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, lorm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>13 Dec 19 71</b> to <b>26 Dec 19 71</b> that (I) (we) last saw the deceased alive on <b>25 Dec 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harvey M. Golomb M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>26 Dec 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARVEY M. GOLOMB M.D.</b>		23D. ADDRESS <b>GOOD SAMARITAN HOSP LOCH RAVEN BLVD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/71</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount Cemetery</b>	
				24D. LOCATION (City, town, or county) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Miller, M.D.</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kelly Jr. N.C. 160 Hollins St</b>	
ADDRESS					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

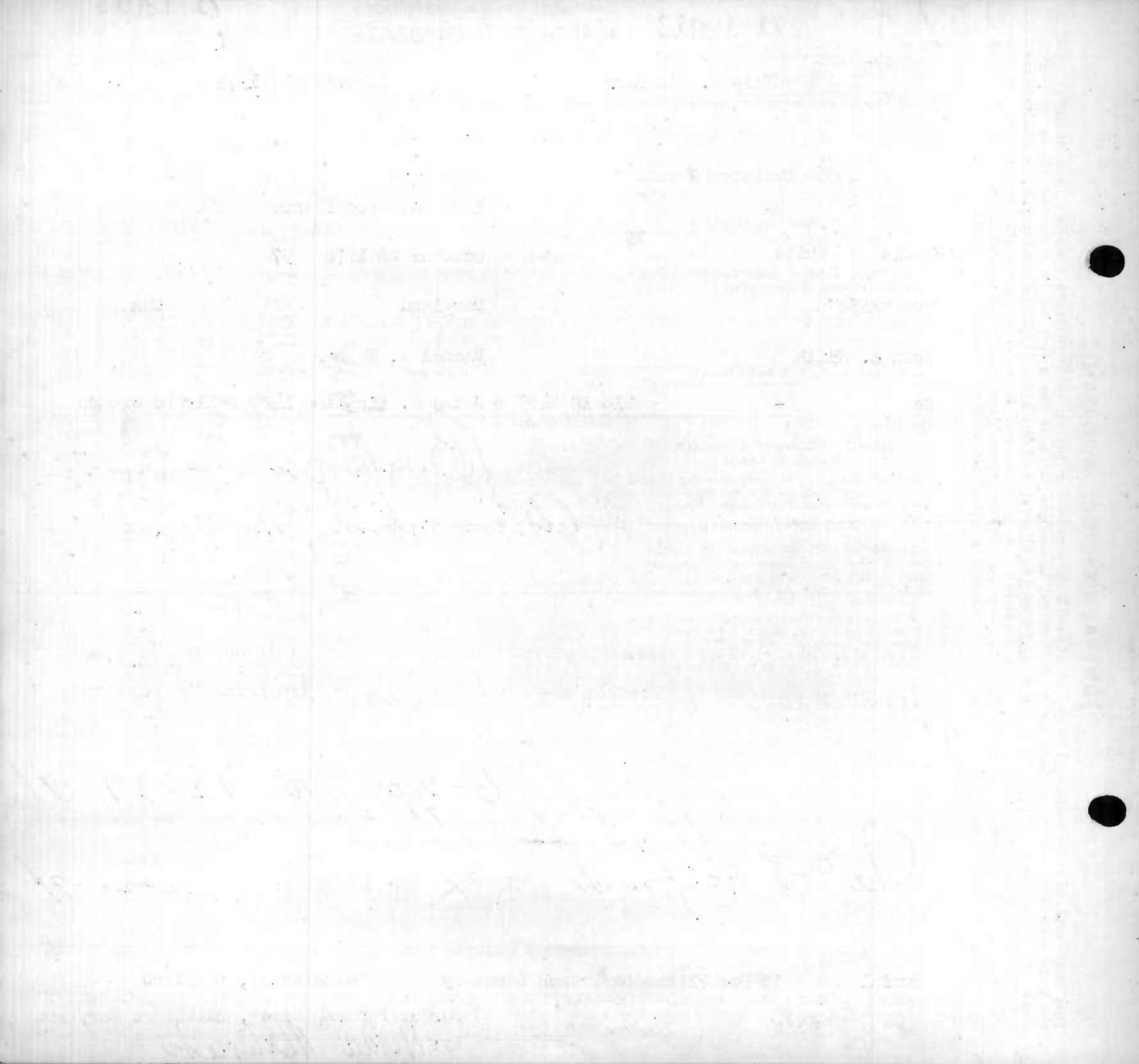
BIRTH NO. <u>M-620</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12012</u>	
1. NAME OF DECEASED (Type or Print) <u>MORRIS EMMA A</u>		2. DATE AND HOUR OF DEATH <u>Dec. 25 71</u>		<u>11<sup>10</sup> P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2719</u>			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-1-95</u>		9. AGE (in years lost birthday) <u>76</u>		If Under 1 Yr., Months: Days Hours: Min. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>412 09 77900</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>George Imhoff</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Cramlitt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown! If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 09 77900</u>		17. INFORMANT <u>R. Pinto</u>	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Cardio Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Acute Myocardial Infarction.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			
MEDICAL CERTIFICATION  19A. DATE OF OPERATION <u>4/10/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 23 1971</u> to <u>Dec. 25 1971</u> that (I) (we) last saw the deceased alive on <u>Dec. 25 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Pinto</u>		23B. DATE SIGNED <u>December 25 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>R. Pinto</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24C. NAME OF CEMETERY or CREMATORIAL <u>Mays Chapel Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert</u>		25C. FUNERAL DIRECTOR <u>Bayridge Funeral Home</u>	
ADDRESS <u>Baltimore Md</u>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

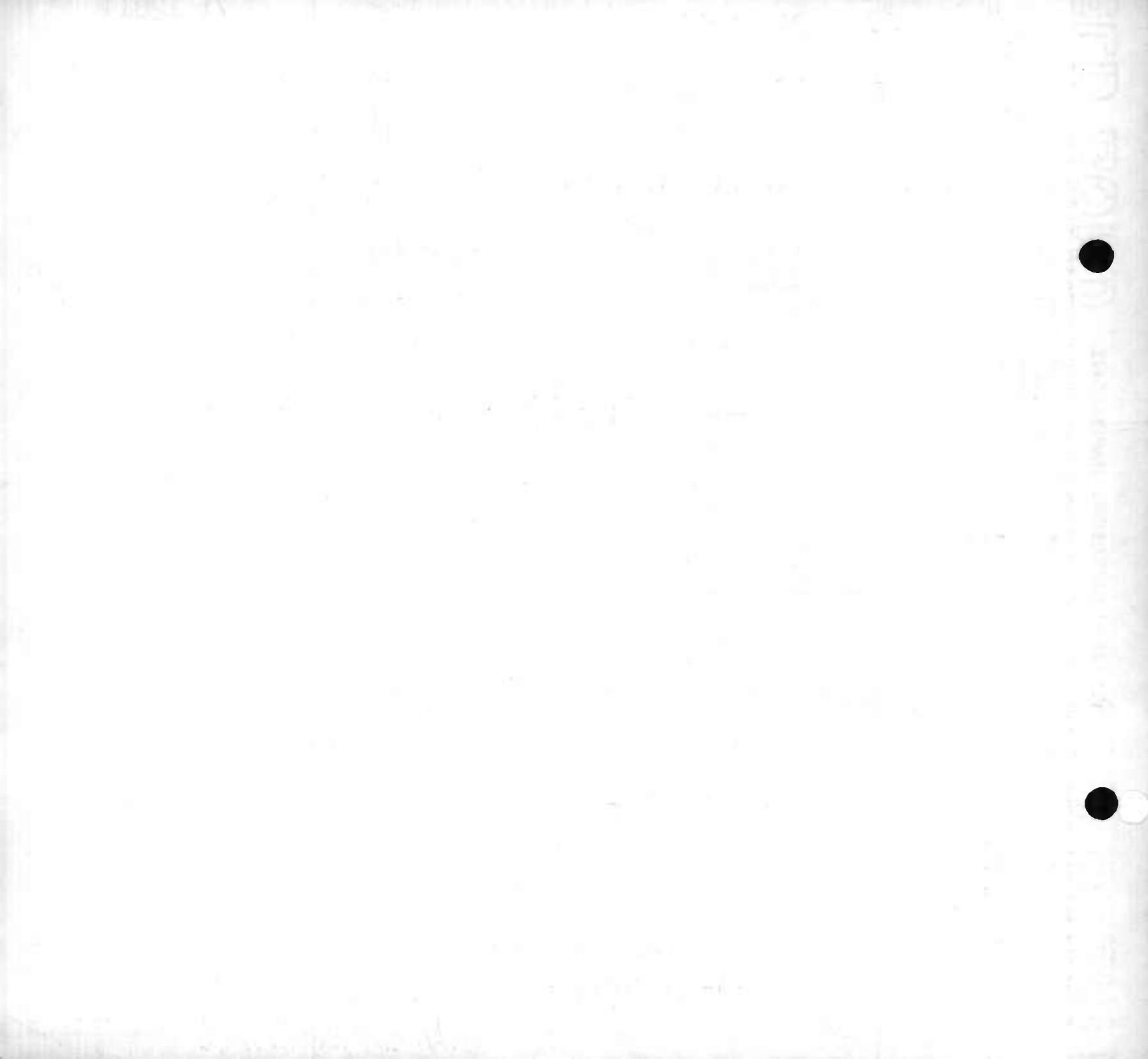
BIRTH NO.		71 12013		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12013		
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH				2. DATE AND HOUR OF DEATH		
Effie T. Yingling						December 27 1971 6 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1348		
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)				C. CITY OR TOWN Baltimore		
00		1406 Dellwood Avenue				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	
Female	White	October 20 1874 97	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Housewife					Maryland	USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
John A. Smith		Rachel E. Wagner						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No		216 10 2425		B Jesse E. Yingling		1406 Dellwood Avenue		
18. 440.91		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Bachlo-primum, terminal						
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  Arterosclerosis, generalized						
		(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								
MEDICAL CERTIFICATION		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						(If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ and that (I) (we) last saw the deceased alive on _____ and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		6-20 1970 to 12-27 1971						
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				12-28-71		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORIUM	24D. LOCATION	(City, town, or county) (State)			
Burial		30 Dec 71	Meadow Branch Cemetery	Westminster, Maryland				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS				
DEC 29 1971		John E. Bailey, R.D.	Burgee Funeral Home	Baltimore Maryland				
VS 150-REV. 1/1/68		By: Norine Blaylock						



**FUNERAL DIRECTOR: IMPORTANT**

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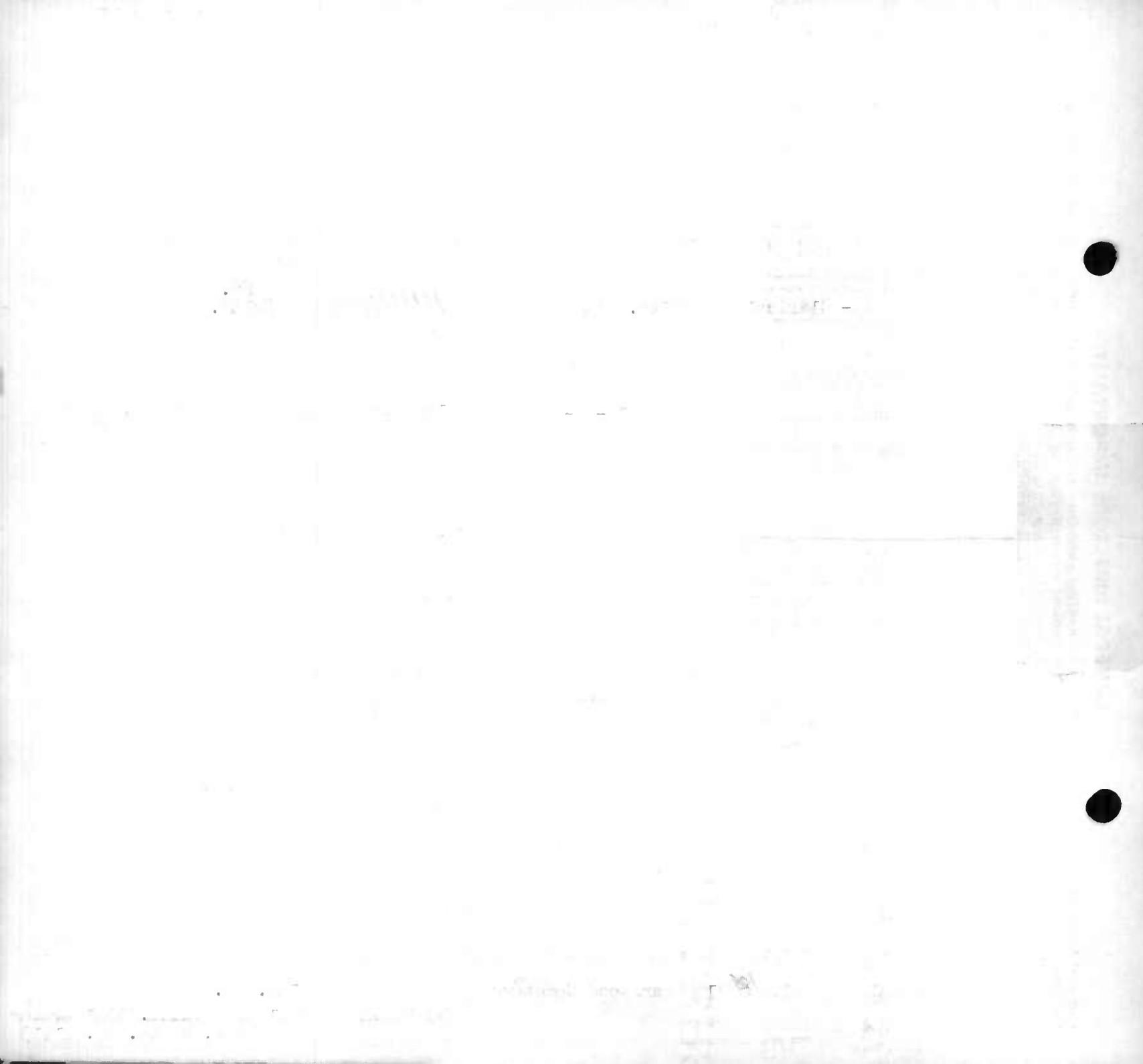
D-120		71 12014		BALTIMORE CITY HEALTH DEPARTMENT	71 12014	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.
1. NAME OF DECEASED (Type or Print)		E. Siffrein Davis		2. DATE AND HOUR OF DEATH		10 40 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE & COUNTY		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		10+40 A.M.
Union Memorial Hospital		Maryland		Baltimore		1307
6. SEX		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years lost birthday)
Female		05/31/01		70 yrs		11 Under 1 Yr Months
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife				Maryland		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Alexander Rich		Ellen MacRoberts				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No		216 14 3326		S. Chaplin Davis		4129 Roland Avenue
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cervix with Extensive Intraperitoneal and liver metastases.				Oct 21 - Dec 26, 71
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:				
		(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSTY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3/12/22/71		CARCINOMA SIGM. - 6/10 COLON LAPAROTOMY		Yes		(If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Initially medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12-20-1971 to 26-12-1971 that (I) (we) last saw the deceased alive on 26-Dec-25-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE		A. J. Karrack MD		Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>
23B. DATE SIGNED						
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORIUM		24D. LOCATION (City, town, or county) (State)
Cremation		27 Dec 71		Greenmount Crematory		Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS
DEC 29 1971		Robert E. Barber, Jr.		Burgee Funeral Home		Baltimore Maryland
By: Robert E. Barber, Jr.						



## FUNERAL DIRECTOR: IMPORTANT

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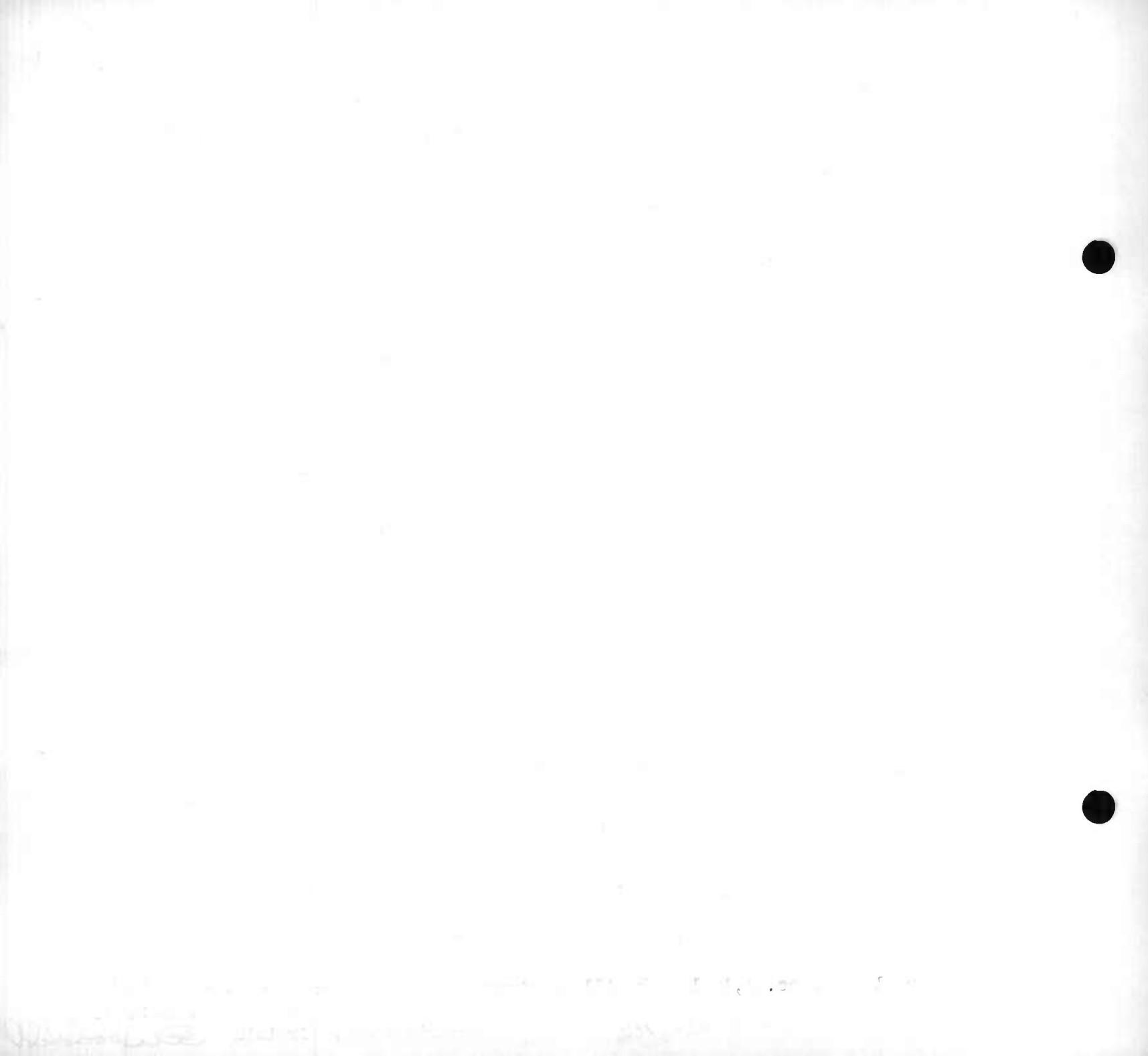
BIRTH NO.		71 12015		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12015	
1. NAME OF DECEASED (Type or Print)		Loos, GEORGE A.		2. DATE AND HOUR OF DEATH 23/12/71 10.30 hrs.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY 2643			
union Memorial Hospital, 4433 Calvert Streets, 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/23/89		9. AGE (in years lost birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerical		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Md. Balto.		12. CITIZEN OF WHAT COUNTRY American			
13. FATHER'S NAME Louis Loos				14. MOTHER'S MAIDEN NAME Johanna Kreis					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown no				16. SOCIAL SECURITY NO. 211-10-5065		17. INFORMANT Ella Loos (wife)		ADDRESS same as above	
18. 472.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure					
				(C) ASCVD, Abdominal Aneurysm					
II MEDICAL CERTIFICATION		21A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <small>(If in Baltimore City, give exact location)</small>	
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? None			
		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no injury			
		22. I certify that (I) (this hospital) attended the deceased from 12/21/71 to 12/23/71 that (I) (we) last saw the deceased alive on 12/23/71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
		23A. SIGNATURE S. Desai M.D.		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. DATE SIGNED 12/23/71			
		23C. PHYSICIAN'S NAME (Type) S. J. DESAI M.D.		23D. ADDRESS union Memorial Hospital 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/27/71		24C. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		24D. LOCATION Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schimmele Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213			



## FUNERAL DIRECTOR: IMPORTANT

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B-326 71 12016		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12016	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/21/71 445 P M			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH BOUTCHYARD</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b> <b>38</b>		4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE & COUNTY <b>MARYLAND BALTIMORE CITY</b>	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/17/07</b>		9. AGE (in years last birthday) <b>64</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>A. BOUTCHYARD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH Rock</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>-</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOGENIC SHOCK</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardiac Infarction</b>		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> to <b>12/21</b> , and that (I) (we) last saw the deceased alive on <b>12/21</b> 1971, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walt Whitman Jr MD</b>		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/21/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALT WHITMAN</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 24, 1971		24C. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	
24D. LOCATION (City, town, or county) <b>Fredericksburg Virginia</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971 Robert E. Faber Jr. M.D.</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wheeler Thompson ADDRESS Fredericksburg, Virginia <b>See back</b>	
VS 150-REV. 1/1/68					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12017		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12017		
1. NAME OF DECEASED (Type or Print)		ELEANOR M. COLLINS		CERTIFICATE OF DEATH				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		2. DATE AND HOUR OF DEATH Dec. 23, 1971, 9:50 P.M.		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY 602		
90 Gould Conv. Home		C. CITY OR TOWN BA HO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 412 N. GLOVER ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-94	9. AGE (in years last birthday) 77	If Under 1 Yr. Months	If Under 1 Day Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Frederick Pretzsch		14. MOTHER'S MAIDEN NAME Laura Winterling		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Anterior stroke heart disease		17. INFORMANT Mary Collins 412 N. Glover St.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) Secondary Anterior DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) Chronic Brain syndrome Cachexia.						
MEDICAL CERTIFICATION	19A. DATE OF OPERATION 12/24/71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)				
	21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Identify medical examiner	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? In Baltimore City					
	21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?					
	22. I certify that (I) (we) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		12/24/71 1970 to 12/25/71					
	23A. SIGNATURE Albert B. Bradley	DEGREE	Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/27/71				
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.	23D. ADDRESS 4900 Belair Road 21206	DEGREE						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-28-71	24C. NAME OF CEMETERY or CREMATORIAL Holy Redeemer Cemetery	24D. LOCATION Baltimore Md.	1. City, town, or county 1. State				
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971	25B. NAME OF REGISTRAR Robert E. Bailey, R.D.	25C. FUNERAL DIRECTOR B. Dobrowski 284 E. Ba Ho. St.	ADDRESS					
VS 150-REV. 1/1/68								



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620 71 12018 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12018	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12-26-71 12 11 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  5 CHURCH Home and Hospital 100 N Broadway		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD U.S.A. B. COUNTY 301			
5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-02 9. AGE (in years last birthday) 69 If Under 1 Yr. Months: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHICAGO. 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John M ROZ		14. MOTHER'S MAIDEN NAME ANNA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-2245		17. INFORMANT JN. Port St. ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Possible MI or CHF DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) Diabetes, RHF DUE TO, OR AS A CONSEQUENCE OF:		(C) ASHD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  R					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-25-71 19 to 12-26-1971 that (I) (we) last saw the deceased alive on 12-26-1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Sajadi		MD DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-26-71	
23C. PHYSICIAN'S NAME (Type) R. SAJADI		23D. ADDRESS CHURCH Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORIAL Holy Rosary Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 Robert E. Sabay, M.D.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR B. Dobrovolski 2618 E. Battle, St.	
ADDRESS					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-630 71 12019		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12019	
1. NAME OF DECEASED (Type or Print) <b>Wanda Gordy</b>		2. DATE AND HOUR OF DEATH <b>12-22-71 6:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles Gen. Hosp.</b> 49		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2636</b>			
5. SEX <b>F</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-6-28</b> 9. AGE (in years lost birthday) <b>43</b> If Under 1 Yr. Months: Days Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mo.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Austin Gunn</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Goodman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-40-183</b>		17. INFORMANT <b>John V 1400 Anglesea St.</b> ADDRESS	
18. <b>15791</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH <b>Pneumonia, Embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ca of the Pancreas</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
20. DATE OF OPERATION <b>12-14-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive Jaundice</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-6 1971</b> to <b>12-22 1971</b> that (I) (we) last saw the deceased alive on <b>12-22 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Narciso E. Ignacio</b>		23B. DATE SIGNED <b>12-22-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>Narciso E. Ignacio</b>		23D. ADDRESS <b>North Charles Gen. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>12-23-71</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>GREENMOUNT Crem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>				(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Explosives 284 E. Bell St. Bt</b>	
ADDRESS					



71 12020

BALTIMORE CITY HEALTH DEPARTMENT

G-412

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12020

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE Known <input checked="" type="checkbox"/> Month 12 Doy 21 Year 71 Hour 3:25 A. M.	
Viola Golebieski		Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION OR INSTITUTION OO		3. DATE PRONOUNCED DEAD Month 12 Doy 21 Year 71 Hour 3:25 A. M.	
(If not in hospital or institution, give street address or location) 6510 Brighton Avenue		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 283	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH March 20, 1890		10. AGE (in years lost birthday) 81 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 6510 Brighton Avenue
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Adam MIROS
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY OWN HOME	15. MOTHER'S MAIDEN NAME Catherine ADDRESS unknown, Baltimore 15
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-18-5846	18. INFORMANT Mrs. Matilda Linnott, 6510 Brighton Ave
19. 4124-14-25019		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: disease	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 24, 1971	24C. NAME OF CEMETERY or CREMATORIAL Holy Rosary Cemetery
24D. LOCATION (City, town, or county) Baltimore		(State) MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 Robert		25B. NAME OF REGISTRAR John A. D.	25C. FUNERAL DIRECTOR Frank H. Newell, Pitmeadville
VS 151-REV. 1/1/68		ADDRESS	

19180

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## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-362 71 12021		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12021	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		DIETRICH MAUDE BEATRICE		2. DATE AND HOUR OF DEATH 12/19/71		12:30PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2841			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4414 BELVIEU AVENUE 21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07/16/84	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN QUINCY POTTER				14. MOTHER'S MAIDEN NAME LYDIA ALMA CROSWELL			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 216 36 5424		17. INFORMANT ST AGNES HOSPITAL BALTO MD 21229		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD and Congestive heart- failure					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/16/71 19 to 12/19/71 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/19/71 19 and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE  TARIQ MAHMOOD		Attending Phys. <input type="checkbox"/>		Med. Director <input type="checkbox"/>		Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD, M.D.		23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229		23E. DATE SIGNED 12.19.71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 22 1971		24C. NAME of CEMETERY Oxford CEMETERY		24D. LOCATION ICity, town, or county) (State) Oxford Md.	
25A. DATE REC'D. BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Gandy, M.D.		25C. FUNERAL DIRECTOR Tariq H. Mahmood, P.D.S., D.Sc.		ADDRESS	

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A-526 71 12022 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12022

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CALVIN AINSWORTH

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4640 Schenley Rd.

6. SEX

male

7. RACE

white

8. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

9. DATE OF BIRTH

28 Feb. 1924

10. AGE (In years lost birthday)

47

If Under 1 Yr.  Under 24 Hrs.   
Months  Days  Hours  Min.

11. BIRTHPLACE (State or foreign country)

Chicago, Ill.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

14B. KIND OF BUSINESS OR INDUSTRY

unknown

17. SOCIAL SECURITY NO.

371 22 9012

18. INFORMANT

Leonard Ainsworth

13. FATHER'S NAME

Harry Ainsworth

15. MOTHER'S MAIDEN NAME

Catherine

McConnell

ADDRESS

5011-3 Green Mt. Ci.

Columbia, Md.

19.

E 88 1 X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Subdural hemorrhage

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1640 Schenley Rd.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12-18-71 P.M.  
12:30 m.

22E. INJURY OCCURRED

WHILE AT WORK  NOT WHILE AT WORK

22F. HOW DID INJURY OCCUR?

Fell while intoxicated

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

12-20-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

24B. DATE

12/23/71

24C. NAME of CEMETERY or CREMATORIUM

Gettysburg National

24D. LOCATION (City, town, or county) (State)

Gettysburg Penna.

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

25B. NAME OF REGISTRAR

Robert S. Fisher, M.D.

25C. FUNERAL DIRECTOR

Higinbotham Slack, Ellicott City, Md.

ADDRESS

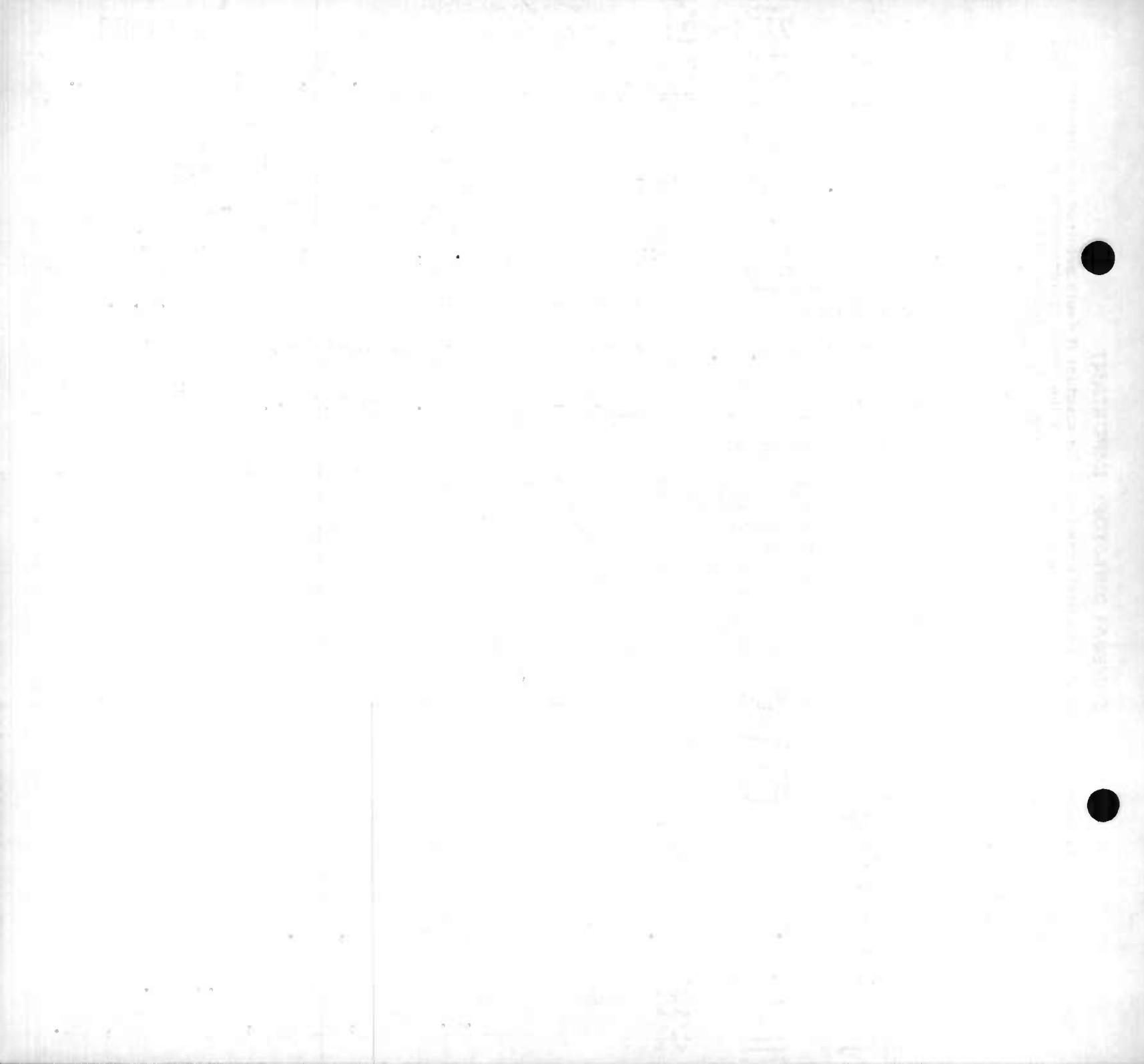
1-3-72 - Letter from Office of the Chief Medical Examiner, Russell S. Fisher, M.D.

HS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

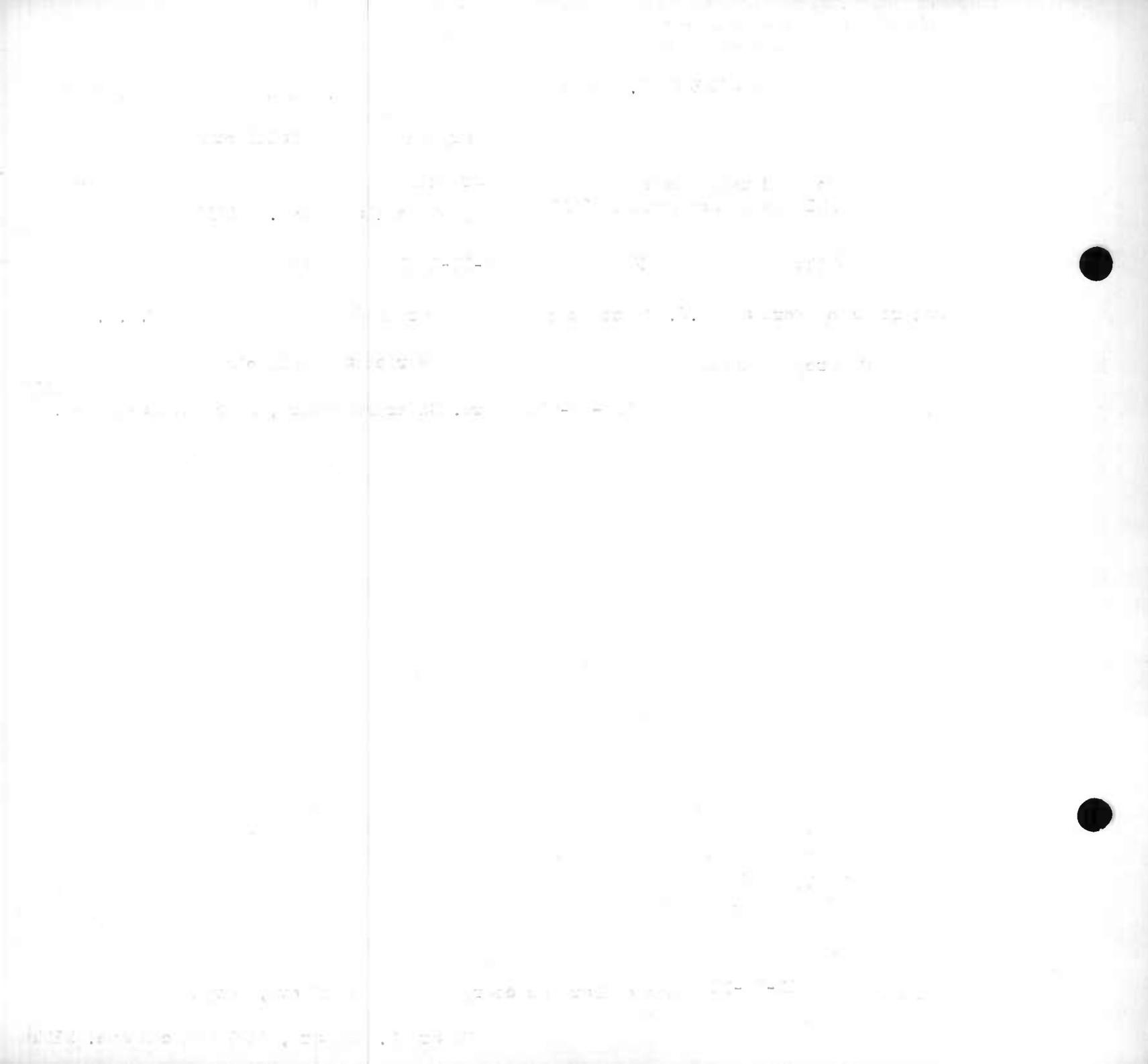
BIRTH NO.		71 12023	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12023
1. NAME OF DECEASED (Type or Print)		NORMAN MULLINIX			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland      Howard 6300 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION  40 St. Agnes Hospital		C. CITY OR TOWN Ellicott City      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER 9106 Dunloggin Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1890	9. AGE (in years less birthday) 81	10. Under 3 Yrs. Months Days Hours 4 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant-retired		10B. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Addison A. E. Mullinix		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown! If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3747A	17. INFORMANT Mrs. Virginia M. Dietrich		ADDRESS Same As #4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE Coronary Thrombosis 1968 DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) 24 Dec 21			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?  1968 19 10 24 Dec 1971	
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard E. Hall		23B. DATE SIGNED 24 Dec 71			
23C. PHYSICIAN'S NAME (Type) Dr. Howard E. Hall		23D. ADDRESS Sykesville, Md. 21784			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/1971	24C. NAME OF CEMETERY or CREMATORIAL McKendree		24D. LOCATION (City, town, or county) Howard Co., Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR C. M. Waltz, Box 326, Sykesville, Md.	
ADDRESS					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

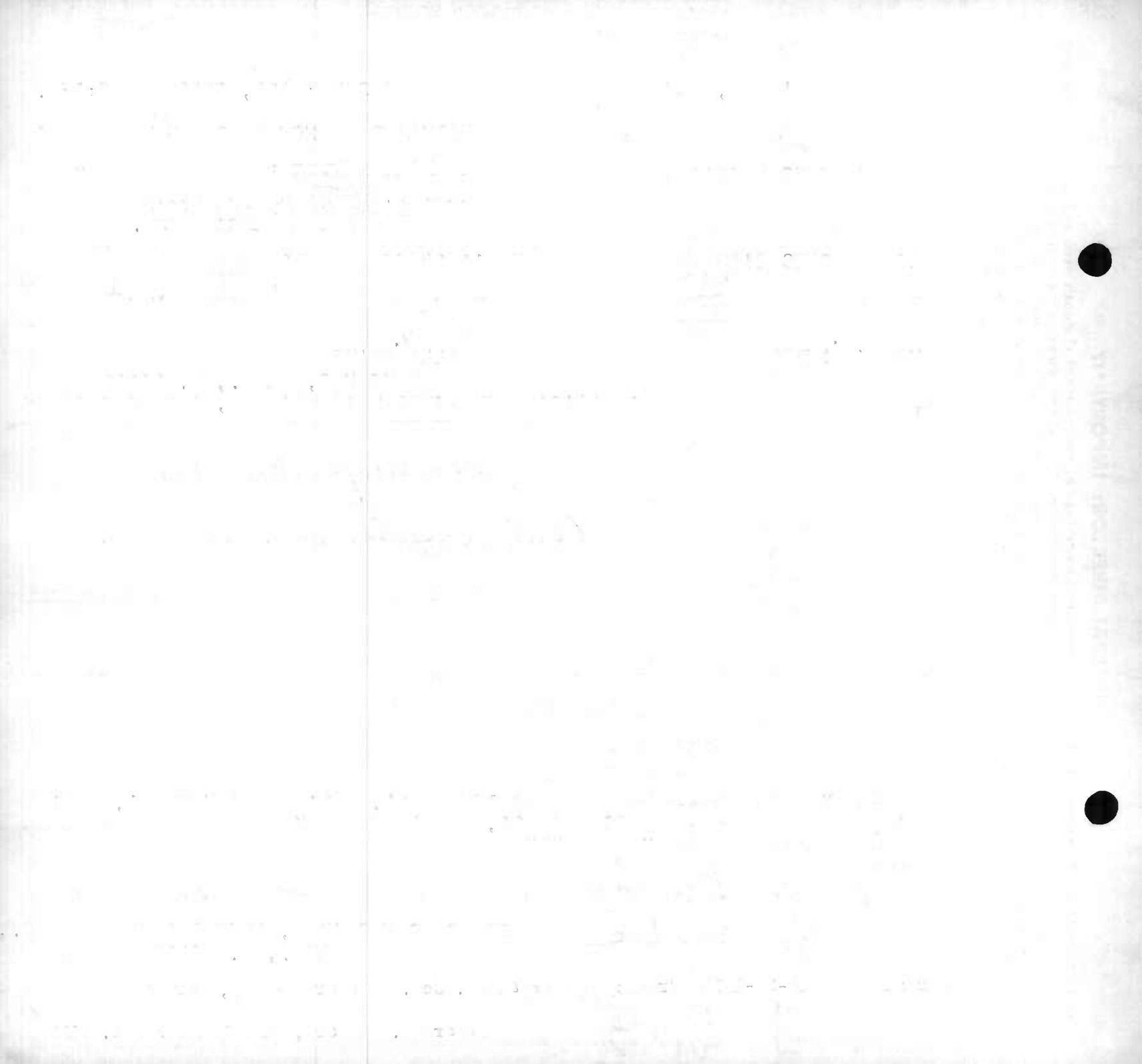
N-200		71 12024	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	REG. NO. 71 12024		
BIRTH NO.		2. DATE AND HOUR OF DEATH DEC 25 1971 4:45 A.M.					
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FREDERICK W. NOWECK		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland Baltimore B. COUNTY 5300					
FULL NAME OF HOSPITAL OR INSTITUTION  90 Hood Nursing Home 5313 Edmondson Avenue 21229		C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX MALE		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1887	9. AGE (in years lost birthday) 84	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shop Foreman		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Godfrey Noweck		14. MOTHER'S MAIDEN NAME Henrietta Malinofski				ADDRESS 21227	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-9415		17. INFORMANT Mrs. Elmer Peddicord, 5003 Westland Blvd.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Cardio. Vasc. Disease -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral atherosclerosis  (C) Parkinsonism					
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If In Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If In Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>No. V.</u> 19 <u>69</u> to <u>Dec 25 1971</u> that (I) (we) last saw the deceased alive on <u>Dec 24 1971</u> and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  HARRY L. KNAPP, MD		23B. DATE SIGNED 12-26-71					
23C. PHYSICIAN'S NAME (Type) HARRY L. KNAPP, MD		23D. ADDRESS 4116 EDMONDSON AV. BALTIMORE, MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-28-71		24C. NAME OF CEMETERY or CREMATORIAL DEGREE Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Gabrey, MD		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

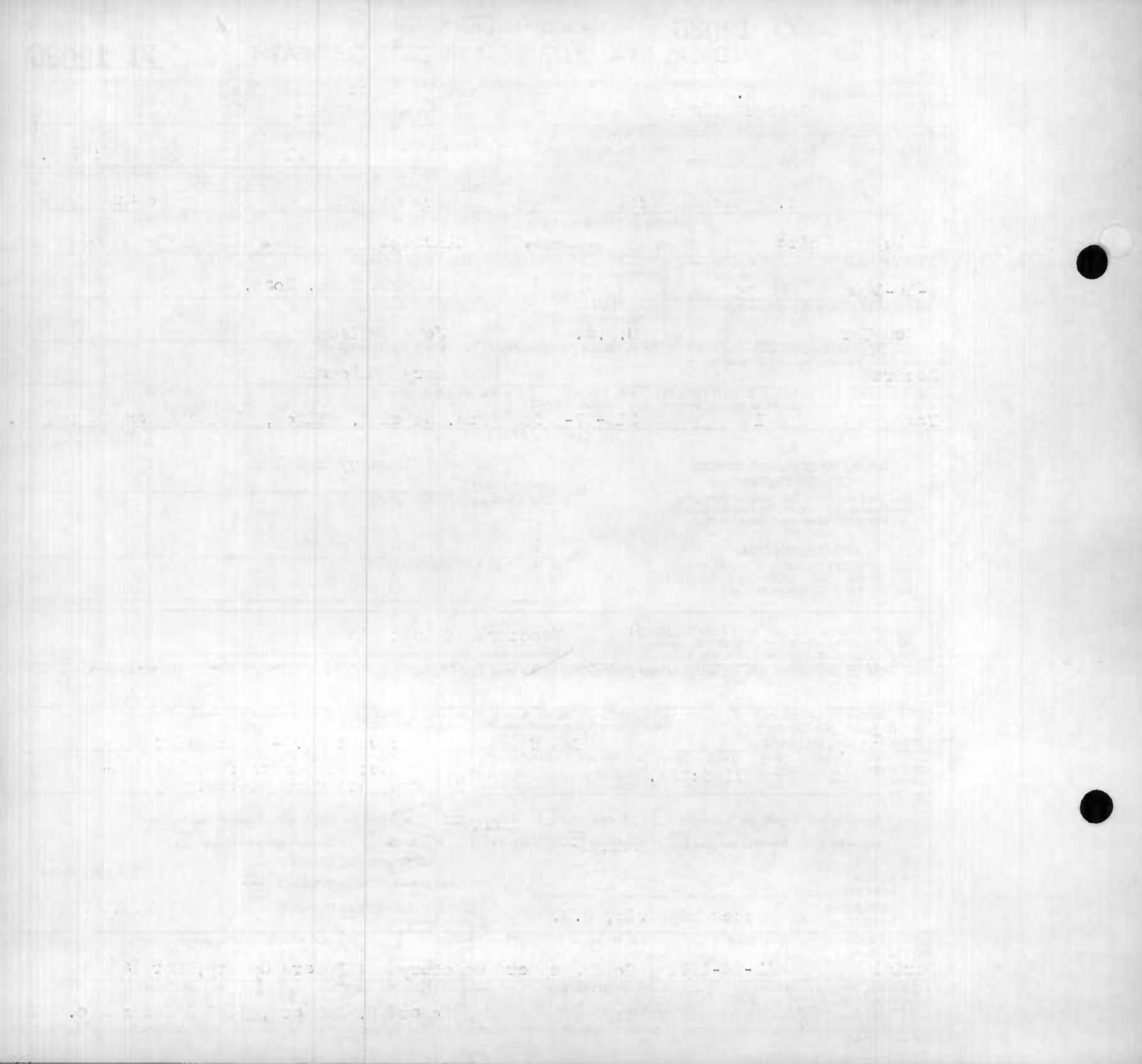
B-536 BIRTH NO. 1. NAME OF DECEASED (Type or Print)		71 12025		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12025	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  40 ST AGNES HOSPITAL				2. DATE AND HOUR OF DEATH DECEMBER 21, 1971   5:15P. M.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD COUNTY 6300			
				C. CITY OR TOWN BETHESDA ELKRIDGE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 3560 WASHINGTON AVENUE 21227			
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/24/00 9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME D. HENRY BINDER				14. MOTHER'S MAIDEN NAME ELLA WHITE			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220241339		17. INFORMANT AVENUES, BALTO., MD. 21229 ST AGNES HOSP RECORDS, WILKENS & CATON			
<p><b>18. 43191 CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(A) IMMEDIATE CAUSE <i>Hemorrhage in Brainstem</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>ANTECEDENT CAUSES</b></p> <p><b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular disease</i></p> <p>(C)</p> <p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Identify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 21, 1971 to DECEMBER 21, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 21, 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <i>J. S. Lee M.D.</i>		23B. DATE SIGNED <i>Dec. 21, 1971</i>		23C. PHYSICIAN'S NAME (Type) <i>Joung Soon Lee</i>		23D. ADDRESS ST AGNES HOSPITAL, WILKENS & CATON AVES., BALTO., MD 21229	
24A. SURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-1971		24C. NAME OF CEMETERY OR CREMATORIUM Trinity Episcopal Ch. Cem.		24D. LOCATION (City, town, or county) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR <i>Ralph E. Barber, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



1  
W-425 71 12026 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12026

BIRTH NO.

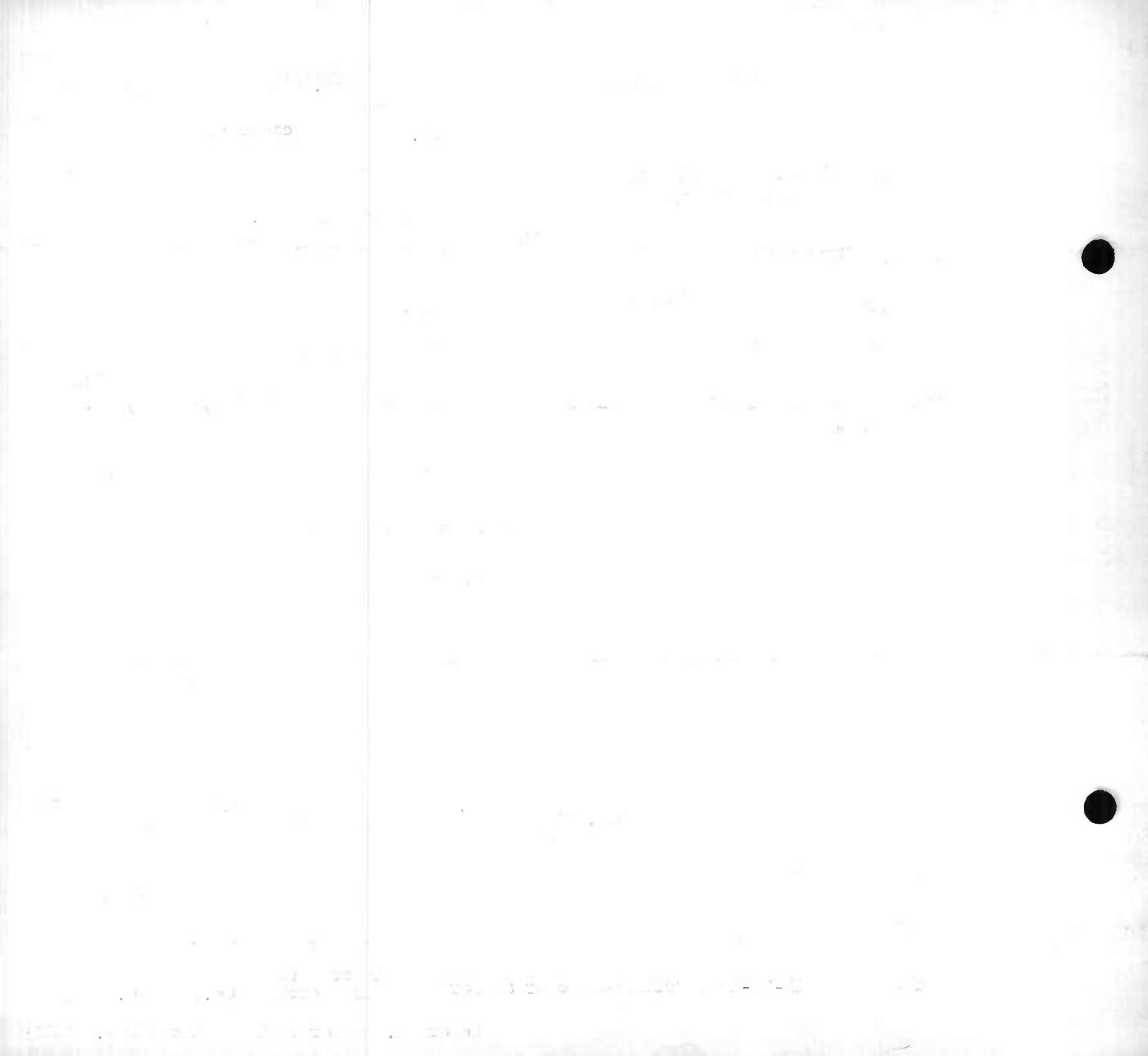
1. NAME OF DECEASED (Type or Print)		B. George Wilson		2. DATE OF DEATH Estimated <input type="checkbox"/> Month 12 Month 12	Known <input checked="" type="checkbox"/> Doy 21 Doy 21	Year 71 Year 71	Hour M. Hour 7:07 p.m.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month 12 Month 12 Doy 21 Year 71 Hour 7:07 p.m.			
40 St. Agnes Hospital				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard			
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Elkridge D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
9. DATE OF BIRTH 9-16-1896		10. AGE (In years last birthday) 75	11. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 6211 Old Wash. Road.			
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Wilson			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary McDonald			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service) Yes W W I		17. SOCIAL SECURITY NO. 215-07-3853		18. INFORMANT Mrs. Ethel S. Wilson, 6211 Old Washington Rd.			
19. <i>450 X 4812.0</i>		CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Pulmonary embolism			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) _____					
II MEDICAL CERTIFICATION 20A. DATE OF OPERATION		Fracture of left hip 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Southwest Blvd - South of Tomday			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 16 71 5:15p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject in car/truck collision- ran into rear of truck			
<p>23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 12/22/71</p> <p>ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Peter Lipkovic</i>, M.D.</p>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-1971	24C. NAME of CEMETERY or CREMATORIUM Good Shepherd Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			
ADDRESS							



## FUNERAL DIRECTOR: IMPORTANT

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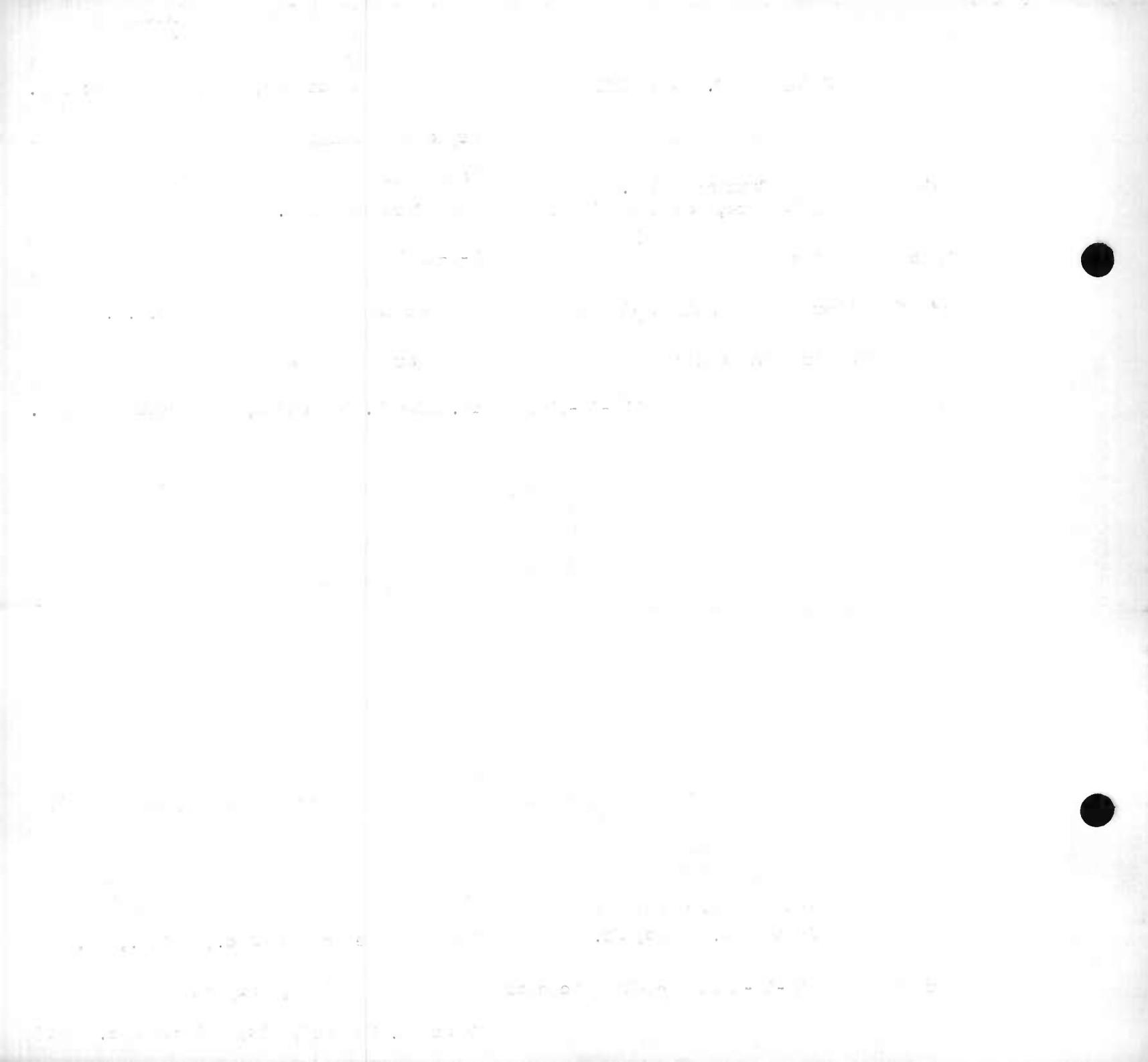
G-642 BIRTH NO.		71 12027		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12027		
1. NAME OF DECEASED (Type or Print)		Richard Groholski		2. DATE AND HOUR OF DEATH Dec. 22, 1971		M. 3:05 A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE Pa. B. COUNTY Westmoreland V35					
5. SEX M 6. RACE Caucasian			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/51		9. AGE (in years last birthday) 20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY USCG Retired		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frank Groholski					14. MOTHER'S MAIDEN NAME Betty Gartley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) Yes			16. SOCIAL SECURITY NO. 174-42-1666		17. INFORMANT Records - US PHS Hospital, Balto, Md.		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH  (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF:  (C) Neuroblastoma					Weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								Months
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 26 1971 to Dec. 22 19 71 that (I) (we) last saw the deceased alive on Dec. 22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <i>John T. Sutherland, M.D.</i>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/22/71			
23C. PHYSICIAN'S NAME (Type) John Sutherland, MD			23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-27-1971		24C. NAME OF CEMETERY OR CREMATORIUM Greenwood Memorial Park		24D. LOCATION (City, town, or county) Lower Burrell West Moreland Co., Penna.		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971			25B. NAME OF REGISTRAR Howard H. Hubbard, 4107 Wilkens Ave.		25C. FUNERAL DIRECTOR ADDRESS 21229			
VS 150-REV. 1/1/68								



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12028		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12028	
1. NAME OF DECEASED (Type or Print)		JOSEPH G. LAUKAITIS		2. DATE AND HOUR OF DEATH December 26, 1971		3:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  4406 Garrison Blvd. Baltimore, Maryland 21215		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 1510			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-7-1902	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		9. AGE (In years last birthday) 69		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Casmir Laukaitis		14. MOTHER'S MAIDEN NAME Mary Bodgon		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-5265		17. INFORMANT Mrs. Alma D. Laukaitis, 4406 Garrison Blvd.		ADDRESS 21215	
18. 41091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Acute Coronary occlusion DUE TO OR AS A CONSEQUENCE OF: Arteriosclerotic degenerative C. V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO OR AS A CONSEQUENCE OF: Parkinsonism.		(C).....			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 70 to 26 Dec. 19 71 that (I) (we) last saw the deceased alive on Nov. 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  Joseph E. Muse Jr.		23B. DATE SIGNED 12/27/71		23C. PHYSICIAN'S NAME (Type) Joseph E. Muse, Jr.		23D. ADDRESS Wilkins & Pine Heights Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-1971		24C. NAME OF CEMETERY or CREMATORIAL Woodlawn Cemetery		24D. LOCATION (City, town, or county) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Fabey, Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229		ADDRESS	



T-425 71 12029

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12029

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert T. Tolson

2. DATE Known  Month Day Year Hour  
DEATH Estimated  12 25 71 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

OO 2612 Maempel La.

3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 25 71 2:20 p.m.

6. SEX

male

7. RACE

White

8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES  NO 

9. DATE OF BIRTH

8-30-1898

10. AGE (In years last birthday)

X 73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Care Taker

14B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

15. MOTHER'S MAIDEN NAME

Mary A. Norman

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-16-5577

18. INFORMANT

Mrs. Sarah E. Krouse, 1145 Linden Ave. 21227 ADDRESS

19. 41214

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT WORK  NOT WHILE  
AT WORK 

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/26/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE (City, town, or county) (State)

12-29-1971

24C. NAME OF CEMETERY or CREMATORIUM

Stevensville Cemetery

24D. LOCATION (City, town, or county) (State)

Stevensville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

VS 151-REV. 1/1/68

25B. NAME OF REGISTRAR

Vickey E. Vaden, R.N.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

ESN 11

feature 2112

ratio of 0.05  
ratio of 0.03  
ratio of 0.03

control point 3133 X - 1000

V C

ratio of 0.03 X - 200

20

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct, or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625 BIRTH NO. 71 12030		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 71 12030	
1. NAME OF DECEASED (Type or Print) <b>Robert S Pearson</b>		2. DATE AND HOUR OF DEATH 12/21/71 11:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Maryland B. COUNTY St. Tammany 6800			
FULL NAME OF HOSPITAL OR INSTITUTION  The Johns Hopkins Hospital		C. CITY OR TOWN Piney Pt. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/15 9. AGE (In years lost birthday) 56 II Under 1 Yr. Months Days Hours II Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Robert Person		14. MOTHER'S MAIDEN NAME Mary Campbell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-2433 17. INFORMANT Grace Barnes			
18. 153.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Nepaloma DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Neoplastic			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C).....			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/24/71 to 12/21/71 that (I) (we) last saw the deceased alive on 11/21/71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Harold Hordern, MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/21/71	
23C. PHYSICIAN'S NAME (Type) J. HAROLD HORDERN, MD		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-23-71		24C. NAME OF CEMETERY or CREMATORIAL St. Luke's	
24D. LOCATION (City, town, or county) St. George Island St. Marys, Md.		24E. DEGREE			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR W.C. Mattingley, Leonardtown, Md. 20650	
ADDRESS					

100

200 300 400 500

600 700 800 900 1000

1000 1100 1200 1300

1400

1500

1600

1700

1800

1900

2000

2100

2200

2300

2400

2500

2600

2700

2800

2900

3000

3100

3200

3300

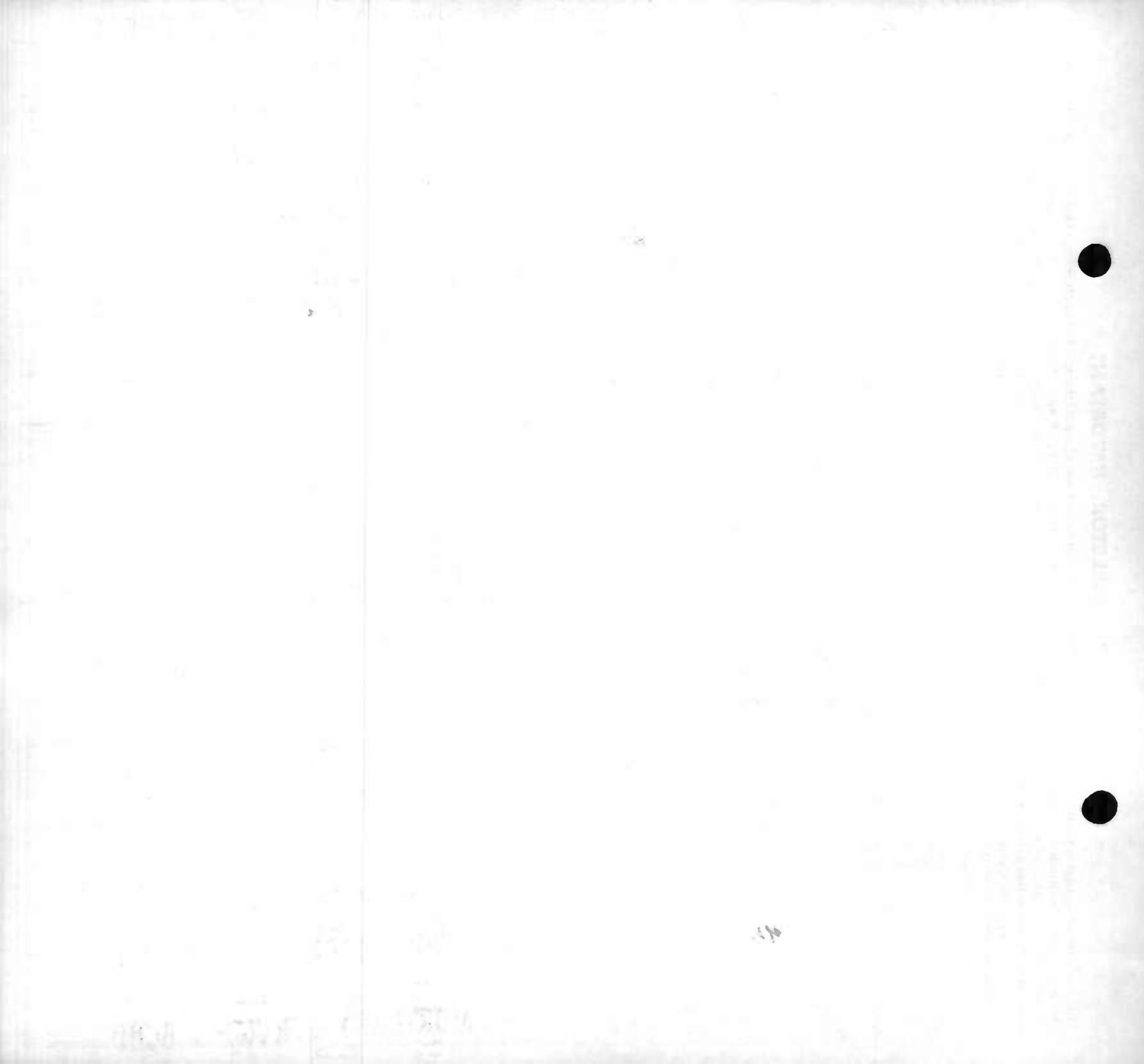
3400

3500

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

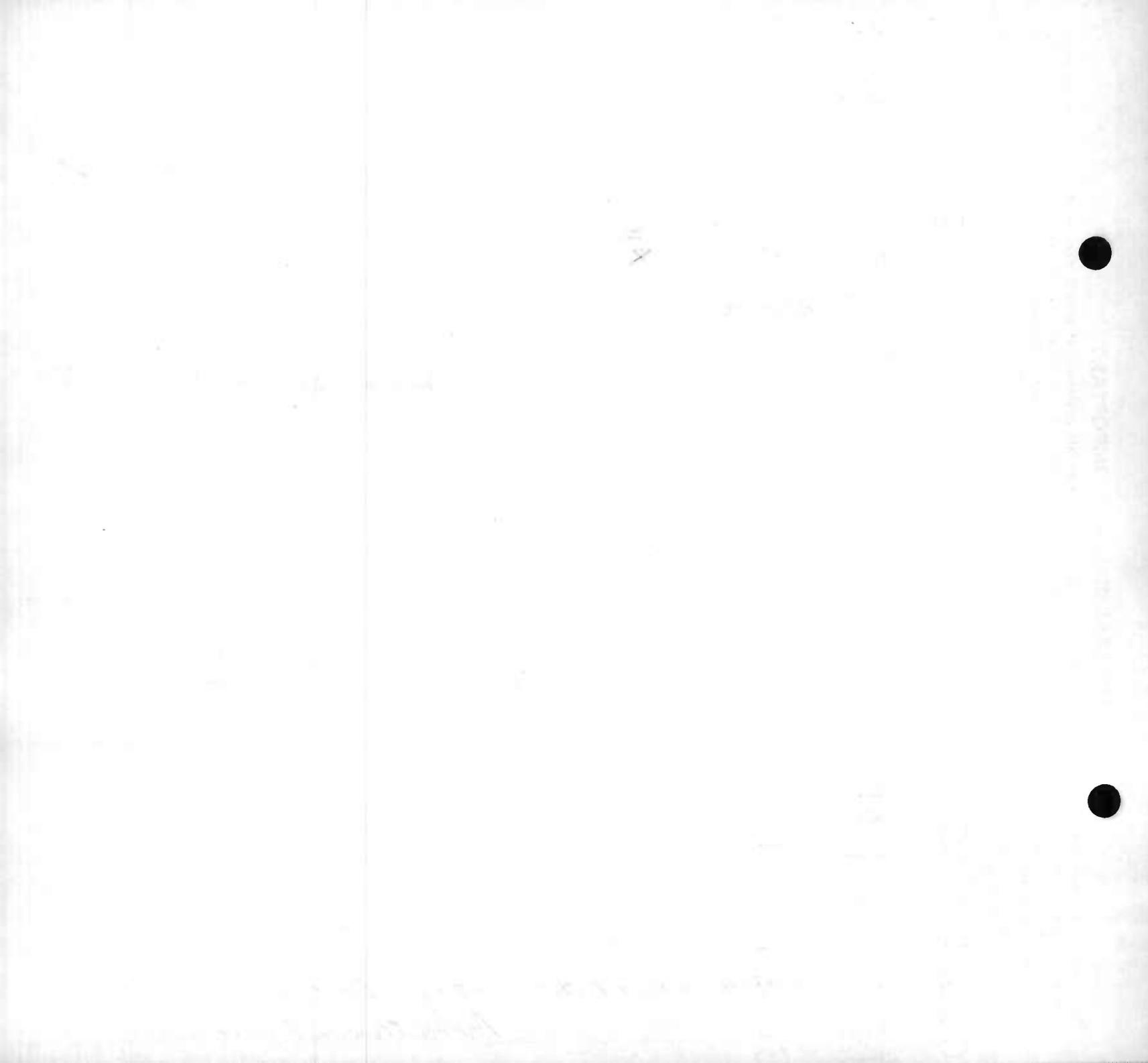
G-416		71 12031	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12031	
BIRTH NO.						
1. NAME OF DECEASED (Type or Print)		CARL GILBERT		2. DATE AND HOUR OF DEATH 12/17/71 12:01 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE MARYLAND		B. COUNTY 1204		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
+4 UNION MEMORIAL HOSPITAL		E. STREET AND NUMBER 2008 CALVERT STREET				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 11/17/71		9. AGE (in years last birthday) 41		10. KIND OF BUSINESS OR INDUSTRY		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH  (A) IMMEDIATE CAUSE EAR DIO RESPIRATORY DISTRESS DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: RHEUMATIC HEART DISEASE			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) HEPATIC FAILURE			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			20A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (In Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/17/71 to 12/17/71 that (I) (we) last saw the deceased alive on 12/16/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						23A. SIGNATURE  RICHARD BRUCKER MD
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS  RICHARD BRUCKER MD UNION MEMORIAL HOSPITAL ANATOMY BOARD OF MARYLAND			23B. DATE SIGNED 12/17/71
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-23-71		24C. NAME OF CEMETERY OR CREMATORIUM JOHNS HOPKINS MEDICAL SCHOOL ANATOMY BOARD OF MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971			25B. NAME OF REGISTRAR Robert E. Zabel, MD		25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-516		71 12032		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12032	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		Katherine SARAH K. HENNEBERGER				2. DATE AND HOUR OF DEATH			
						12-23-71 (3:55 am)		3:55 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived; II institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		MARYLAND (CITY) BALTO 5300			
44 UNION MEMORIAL HOSPITAL									
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) 66	
FEMALE		White				01-10-1905		II Under 1 Yr. Months Days Hours II Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED AT HOME		—		MARYLAND		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
WALTER C. LIPS		ELSIE M. BAILEY 21229							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		216-14-1397		Kenneth R. Henneberger - 417 Kensington Rd Makatherine Shuldice Dudley Lane					
18. 153.31		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Dehydration				6 days			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  Vomiting				6 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:  Abdominal carcinomatosis- (sigmoid carcinoma)				5 months			
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 17-22-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Large sigmoid obstruction		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-20-1971 to 12-23-1971 that (I) (we) last saw the deceased alive on 12-22-1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE  Cesar Alegre MD		23B. DATE SIGNED 12-23-71							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Union Memorial Hospital							
CESAR A. ALEGRE MD		DEGREE							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-27-71		24C. NAME OF CEMETERY OR CREMATORIY Dundridge Cemetery		24D. LOCATION Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 89 1971		25B. NAME OF REGISTRAR M. E. S.		25C. FUNERAL DIRECTOR Amarost Funeral Chapel - 4600 Liberty Height		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-320 BIRTH NO. 1. NAME OF DECEASED (Type or Print)		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12033	
71 12033 Sutch Mabel Irene		2. DATE AND HOUR OF DEATH 12/24/71		8:10 a.m. Balto. Md.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Pleasant Manor Nursing Home 4615 Park Heights Avenue Baltimore Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 301			
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/05		9. AGE (in years last birthday) 66 If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Cumberland Balto. Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-05-4438		17. INFORMANT Warren White 3401 Milford Avenue	
18. 4367 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  <b>Bronchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  CVA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  Secondary Hemiparesis			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/2/71 to 12/24/71 that (I) (we) last saw the deceased alive on 12/23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward Kallins		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/24/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6611 Greenspring Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/71		24C. NAME OF CEMETERY OR CREMATORIAL Baltimore National	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR E. Walker, Jr.		25C. FUNERAL DIRECTOR Armstrong Chapel - 4608 Liberty Hall	
ADDRESS					



S-5301 12034

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12034  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Andrew Smith

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*00*(If not in hospital or institution, give street  
address or location)

1051 N. Aisquith Street

6. SEX  
male7. RACE  
Negro

9. DATE OF BIRTH

3-27-27

10. AGE (in years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Unemployed*

14B. KIND OF BUSINESS OR INDUSTRY

-

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL SECURITY NO.

9-28-58-58-52 239462532

18. INFORMANT

James Smith - 1116 N. Lorraine Ave.

19. CAUSE OF DEATH

Stabwound of chest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1051 N. Aisquith St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12 25 71 unk22E. INJURY OCCURRED  
WHILE AT WORK NOT WHILE   
AT WORK 

22F. HOW DID INJURY OCCUR?

Subject stabbed during altercation

23.

I certify that I held on Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)*Peter Lipkovic, M.D.*CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/25/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORIAL

Burial  
DEC 29 1971

Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

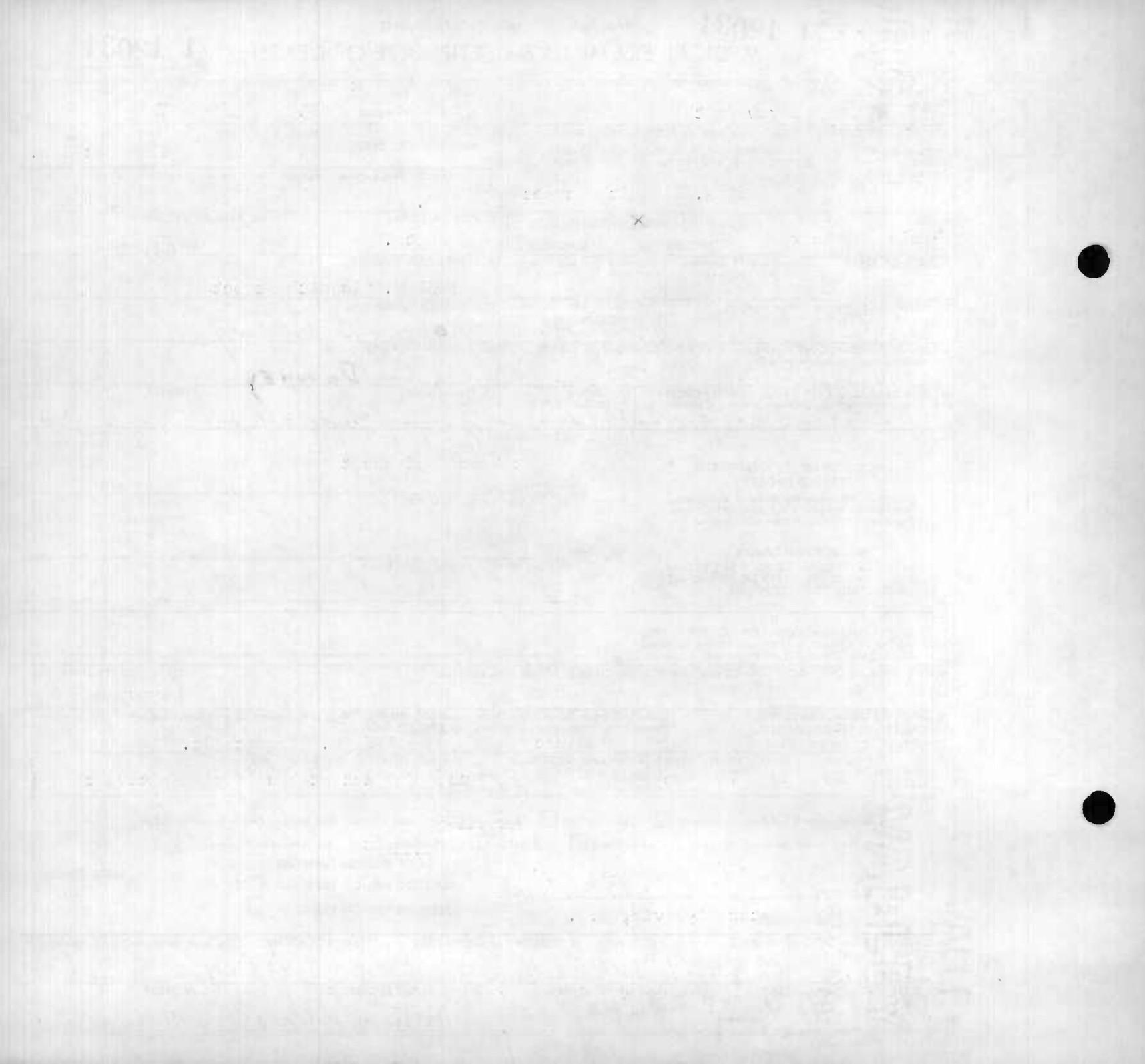
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Robert E. Valley, M.D.

Milton E. Ellickson - 1129 N. Caroline St.



W-452 71 12035

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12035

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter Williams

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2016 Ellsworth St.

6. SEX  
male7. RACE  
Negro

9. DATE OF BIRTH

9-18-95

10. AGE (In years  
lost birthday)

76

11. BIRTHPLACE (State or foreign country)

Va.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Construction Worker

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.I.

17. SOCIAL SECURITY NO.

218-09-4482

18. INFORMANT ADDRESS

Elizabeth Williams - 2016 Ellsworth St.

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

## MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK  NOT WHILE  
AT WORK 

23.

I certify that I held on Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/26/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORI

24D. LOCATION (City, town, or county) (State)

Burial

12-30-71

MT. Calvary Cemetery

A.A. County Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

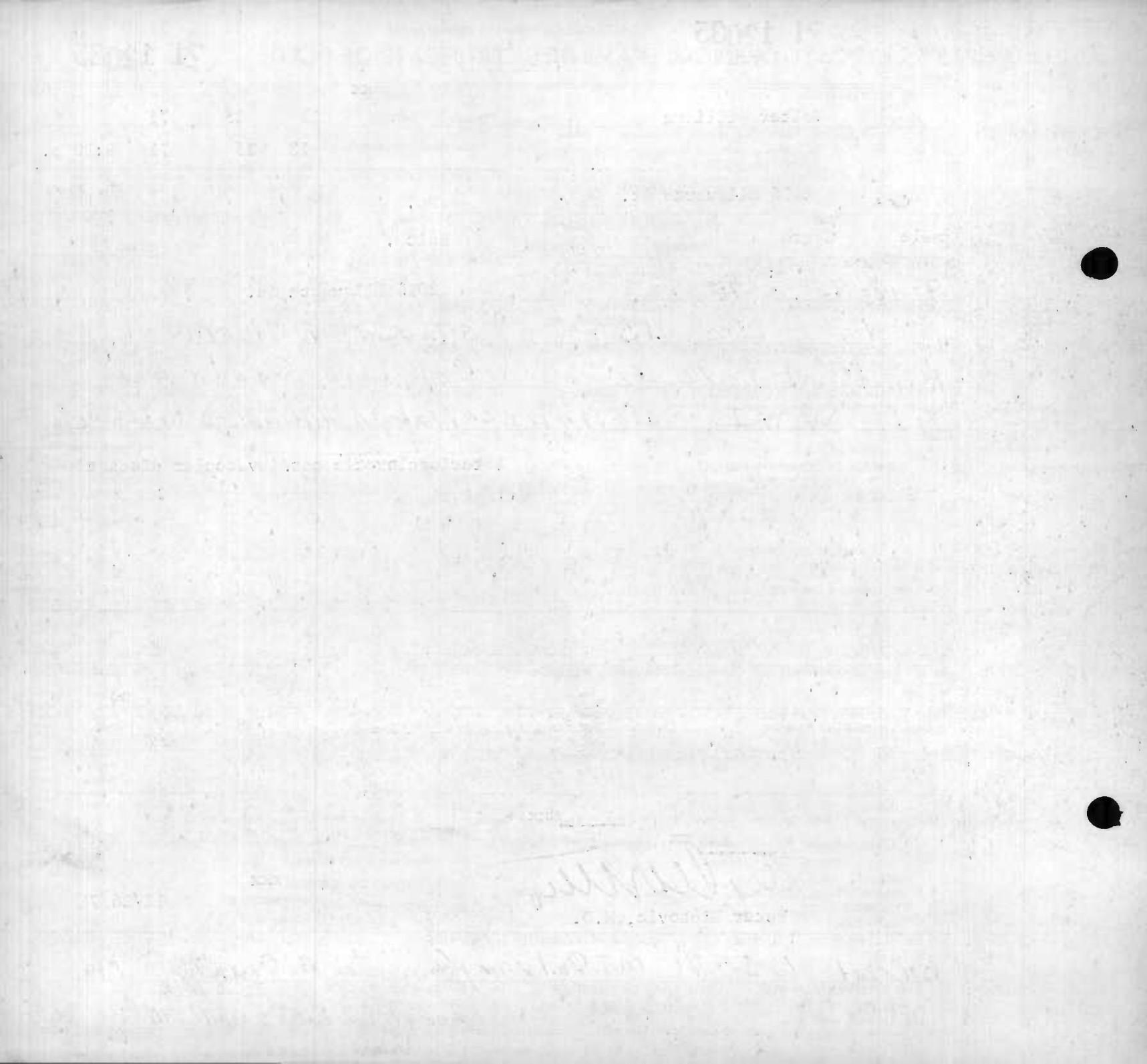
25C. FUNERAL DIRECTOR

ADDRESS

DEC 29 1971

Robert E. Faber, M.D.

Dorothy L. Hicks, 1129 N. Carroll St.



C-615

71 12036

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12936

**BIRTH NO**

1. NAME OF DECEASED (Type or Print)		2. DATE Known <input type="checkbox"/> Month Doy Year Hour			
Montgomery CURBEAM		DEATH Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE Month Doy Year Hour			
Johns Hopkins Hospital		PRONOUNCED DEAD 12 27 1971		12:27 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE Md.		B. COUNTY 804	
6. SEX female		7. RACE negro		C. CITY OR TOWN Balto.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9-3-52		10. AGE (In years lost birthday) 19		E. STREET AND NUMBER 2214 Henndel Ave.	
Months: Days:		If Under 1 Yr. If Under 24 Hrs. Hours: Min.			
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF USA		13. FATHER'S NAME Willie Blate Curbeam	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Aide		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Enrichy Hill	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Willie Curbeam - 2214 Henndel Ave	
19. E9651 X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE TWO gunshot wounds of chest DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bar		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2205 Mura St.	
22D. TIME (Month) (Doy) (Year) (Hour) (APPROX.) 12-27-71 12:15 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE _____ M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORIAL Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Westport, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 Robert		25B. NAME OF REGISTRAR E. Jaiber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Frank J. Clinton - 11297 Cambinst	

1

## **FUNERAL DIRECTOR: IMPORTANT**

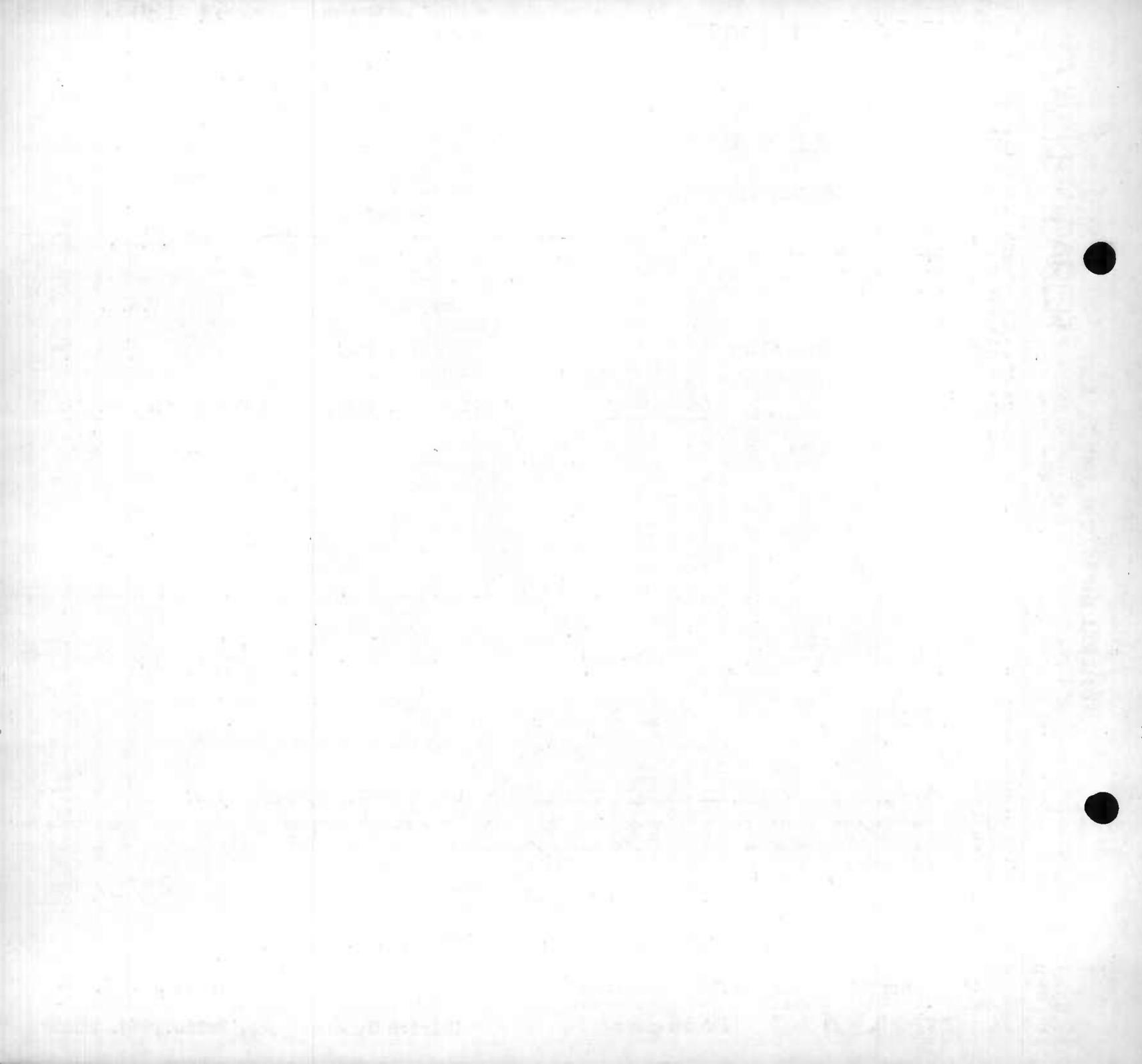
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-256 71 12037  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

71 12037

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
BERTHA R. D. ECKMEYER		15 December 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
00 900 McKewin Ave.			
5. SEX		6. RACE	
Female		Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Kline			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT  William H. Eckmeyer, 900 McKewin Ave. 21218	
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE  Dr. D.W. Mintzer		23B. DATE SIGNED  12/16/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS  D.W. Mintzer, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) bimial		24B. DATE 18 Dec. 71	
24C. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		24D. LOCATION Baltimore County, Md. 21224	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 Robert E. Johnson, A.D.		25B. NAME OF REGISTRAR	
		25C. FUNERAL DIRECTOR Ullrich Funeral Home, Balto., Md. 21206	
9.30A 903			



## FUNERAL DIRECTOR: IMPORTANT

S-220 71 12038

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

X REG. NO.

71 12038

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sheuchik Mary N.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

CHURCH Home & Hospital  
BROADWAY & FAYETTE. St.

2. DATE AND HOUR OF DEATH

12/17/71

8<sup>15</sup>  
A.M.

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

Md.

B. COUNTY

BALTIMORE

5300

C. CITY OR TOWN

BALTIMORE DOWDAK

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER

231 Detroit Ave. 21222

5. SEX

6. RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

03-22-93

9. AGE IN YEARS  
(last birthday)

78

If Under 1 Yr.  
Months:

Days:

Hours:

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

013-07-64007

11. BIRTHPLACE (State or foreign country)

UKRAINE

12. CITIZEN OF WHAT COUNTRY?

U.S.S.R.

18. 174X I

#### DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

#### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

17. INFORMANT

KATHERINE JUPRIK. II LIBERTY PKWY. 21222

ADDRESS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE Pulmonary Insufficiency - Lung failure 48 hours  
DUE TO, OR AS A CONSEQUENCE OF: Probable pulmonary embolism  
or Thrombosis

(B) DUE TO, OR AS A CONSEQUENCE OF: Lung resection 2 mo to Ca aft Breast

(C) Congestive Heart failure - Pulmonary insufficiency

cerebral Arteriosclerosis - Pulmonary fibrosis  
status post-mastectomy (left) → Lymphedema left arm

#### MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF  
DEATH (Initially medical examined)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office, bridge,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
(Month) (Day) (Year)  
OF INJURY  
(APPROX.)

11/28 1971

21E. INJURY OCCURRED  
While At   
Not While   
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

11/28 1971 to 12/17 1971

that (I) (we) last saw the deceased alive on

12/17 1971 end that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ashwin Mehta

MD

DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

12/17/71

23C. PHYSICIAN'S  
NAME (Type)

D. ASHWIN MEHTA MD

23D. ADDRESS

Church Home & Hosp. Balt. 21231

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

20 DEC 71

24C. NAME OF CEMETERY OR CREMATORIUM

SACRED HEART CEMETERY

24D. LOCATION  
(City, town, or county)

BALTIMORE CO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

25B. NAME OF REGISTRAR

Robert L. Vining Jr.

25C. FUNERAL DIRECTOR

ASHWIN MEHTA

ADDRESS

ASHWIN MEHTA



W-400

71 12039

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12039

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jessie Wells

2. DATE Known  Month Day Year Hour  
Estimated  12 28 71 8:07 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*43*

South Baltimore General Hospital

3. DATE  
PRONOUNCED DEAD  
Month Day Year Hour  
12 28 71 8:07 A. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland  
B. COUNTY *1607*

6. SEX

Male

7. RACE

Negro

8. MARRIED

NEVER MARRIED 

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

9. DATE OF BIRTH

*Aug 17-1918*10. AGE (In years  
last birthday)

53

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1210 Oakhurst Place

11. BIRTHPLACE (State or foreign country)

*Maysville S.C.*

12. CITIZEN OF

*WHAT COUNTRY?*

13. FATHER'S NAME

*Isaac Wells*

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laconon*

14B. KIND OF BUSINESS OR INDUSTRY

*Rubber Neck Co*

15. MOTHER'S MAIDEN NAME

*Honoretta Howery*16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL SECURITY NO.

217-05-8834

18. INFORMANT

ADDRESS

*Werner Wells 2429 W. Colored Dr. N.E.*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the cause of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE Subarachnoid hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)WHILE AT  
m. WORK 22E. INJURY OCCURRED  
NOT WHILE  
AT WORK 

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner Deputy CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-28-71

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORIUM

24D. LOCATION (City, town, or county) (State)

*Burnside**12/31/71**NYC Crematorium**Baltimore*

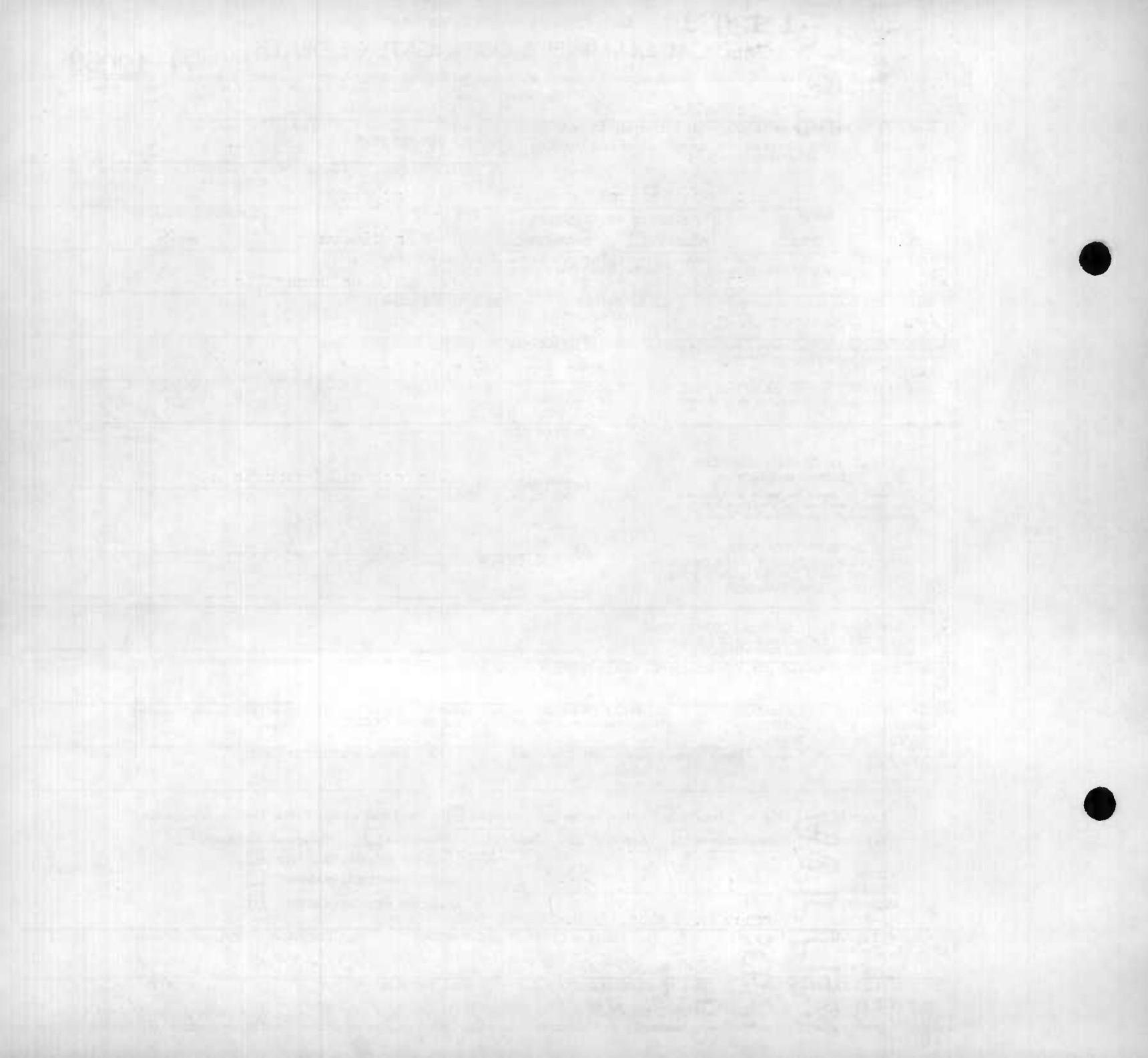
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

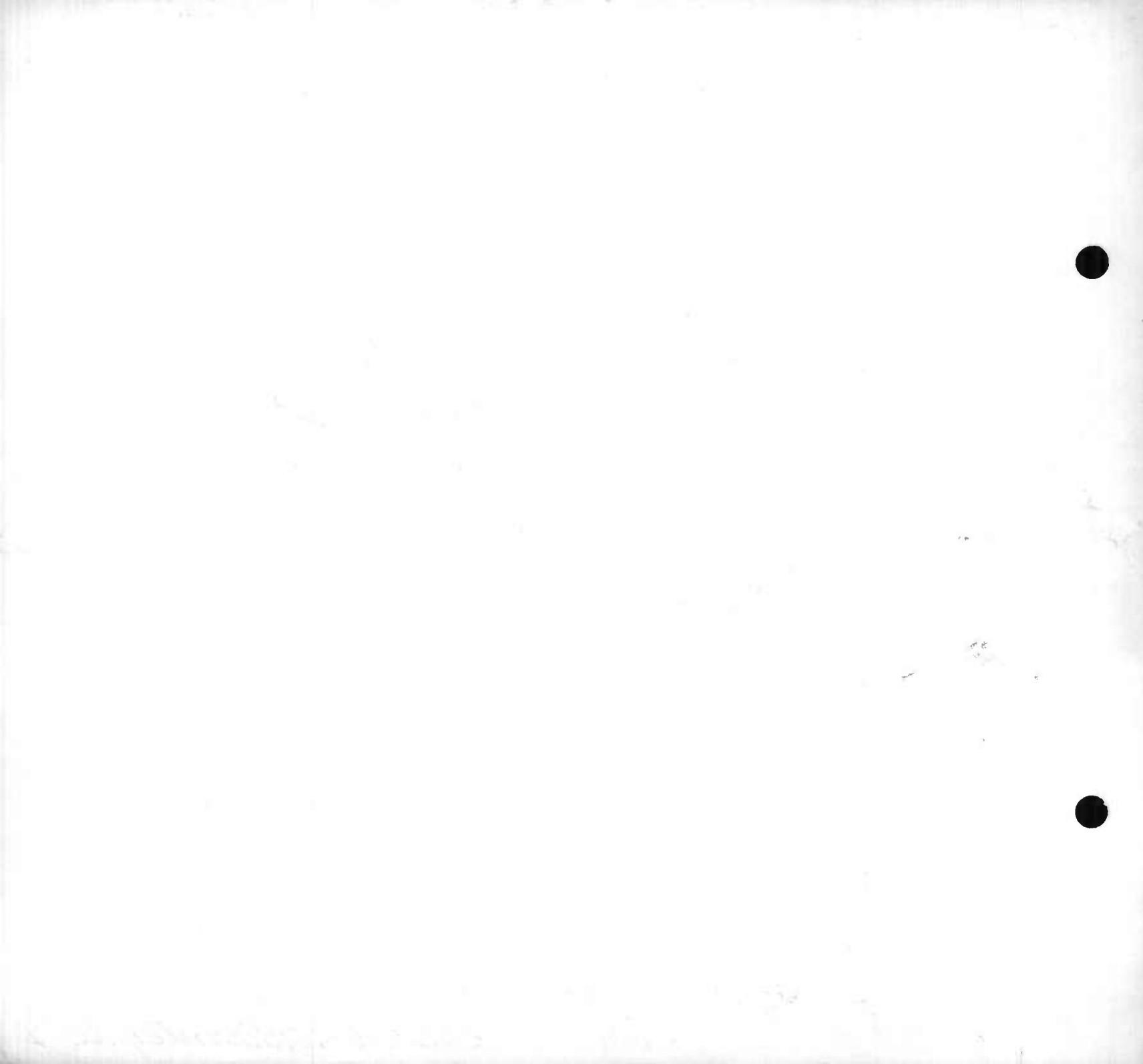
*DEC 29 1971**Robert E. Faber, M.D.**Worthington & Hayes 638 n. Gower St*



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12040	
BIRTH NO. 71 12040					
1. NAME OF DECEASED (Type or Print) SIMMONS BEATRICE				2. DATE AND HOUR OF DEATH 12/26/71 10:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY BALTO	
5. SEX FEM RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/1887 9. AGE (in years lost birthday) 84 If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Jerry Pruitt				12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever In U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Unknown	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/24/71	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carbs Vocal accident	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)				(D)	
MEDICAL CERTIFICATION				20A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 12/26/71	
23A. SIGNATURE		M.D. Degree		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS DAVID GLASER, M.D.		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-71		24C. NAME OF CEMETERY or CREMATORIAL Whitman	
24D. LOCATION (City, town, or county) Whitman				24E. (Street)	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR	
				ADDRESS	

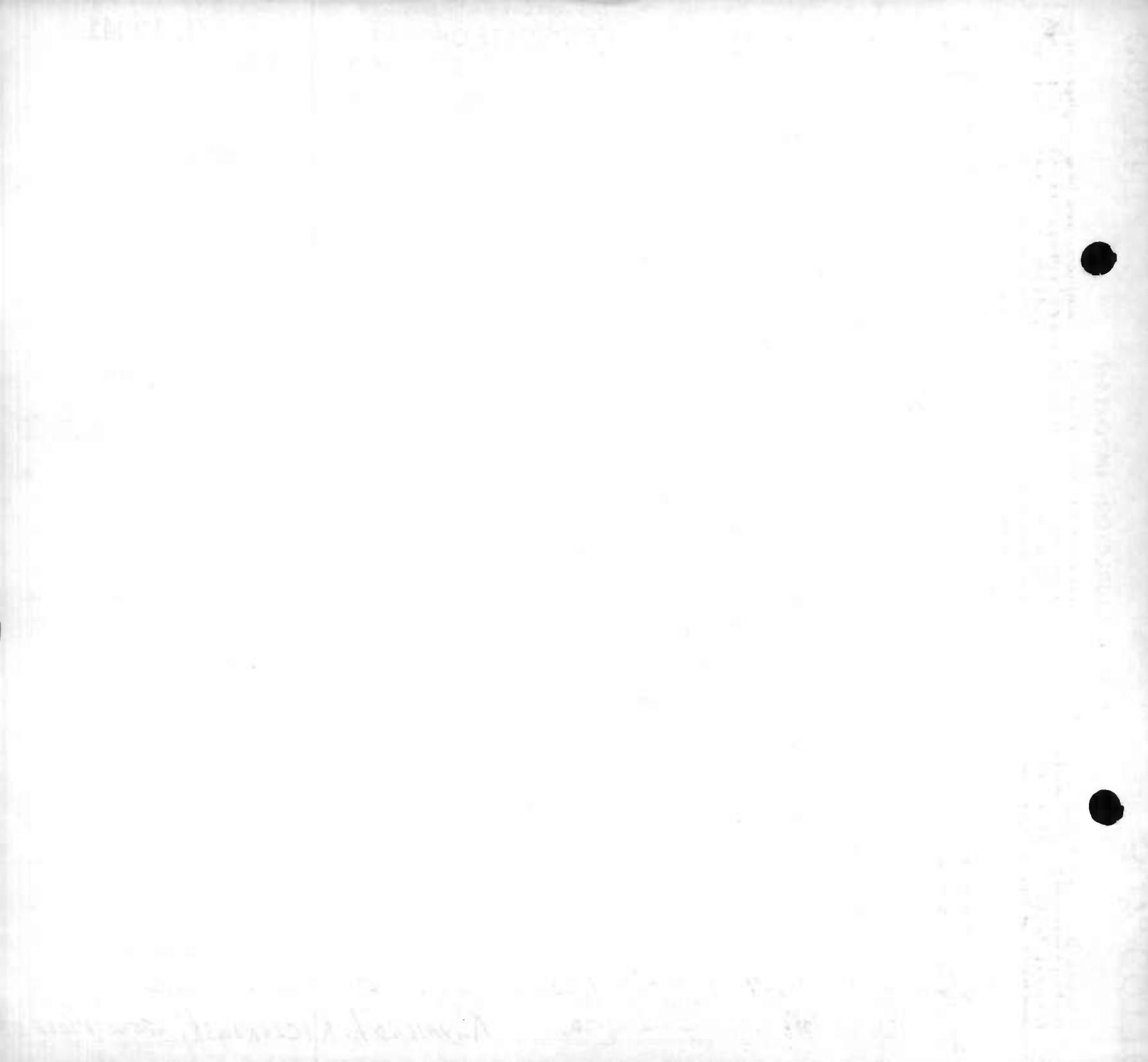


**FUNERAL DIRECTOR: IMPORTANT**

B. 426  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

BIRTH NO. <u>71 12041</u>		REG. NO. <u>71 12041</u>	
1. NAME OF DECEASED (Type or Print) <u>STELLA BALCEROWICZ</u>		2. DATE AND HOUR OF DEATH <u>12-21-71 17-50 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Church Home Hospital 100 N Broadway St Baltimore MD 21231</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>102</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>100 N Broadway St</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>602 S. ELLWOOD AVE</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05-07-94</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9. AGE (in years lost birthday) <u>77</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Walter Balczynska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT <u>A friend now Church Home Hosp</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>AS P.V.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>	
20A. AUTOPSY? Yes or No <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID INJURY OCCUR? <u>None</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) <u>None</u> (Day) <u>None</u> (Year) <u>None</u> (Hour) <u>None</u>		21E. INJURY OCCURRED <u>None</u> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>None</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>11-30</u> 19 <u>71</u> to <u>12-21</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/21/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>S. P. Indolos</u>		23B. DATE SIGNED <u>12/21/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEMMA P. INDOLOS</u>		23D. ADDRESS <u>Church Home &amp; Hospital</u>	
24A. BURIAL CREMATION, DATE REMOVAL (Specify) <u>Burial 12/24/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore MD.</u>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Saenger M.D.</u>	
25C. FUNERAL DIRECTOR <u>Raymond Kaczorowski</u>		ADDRESS <u>2525 FLEET ST.</u>	



J-525

71 12042

BALTIMORE CITY HEALTH DEPARTMENT

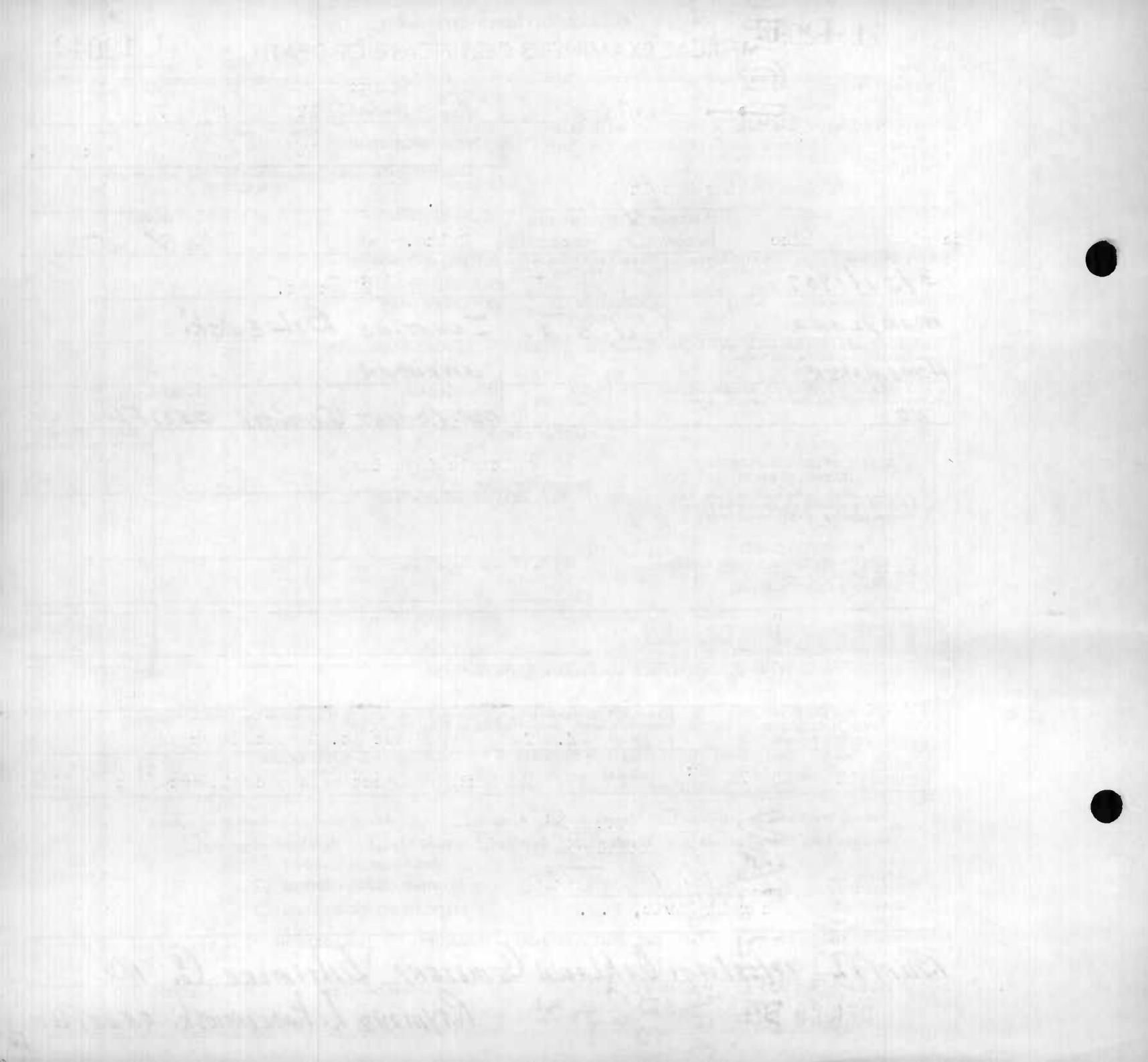
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12042

## BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE Known <input checked="" type="checkbox"/> Month 12 Day 23 Year 71 Hour M. Estimated <input type="checkbox"/>	
Mary Jamison JAMISON		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>John Hopkins Hospital</i>		3. DATE PRONOUNCED DEAD Month 12 Day 23 Year 71 Hour 8:30 p.m.	
6. SEX Female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 3/24/1907		10. AGE (In years last birthday) 64	E. STREET AND NUMBER 2509 Fleet St.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		14B. KIND OF BUSINESS OR INDUSTRY	G. FATHER'S NAME Ignatius Bollewski
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		H. SOCIAL SECURITY NO.	I. MOTHER'S MAIDEN NAME UNKNOWN
19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		J. CAUSE OF DEATH Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
K ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		L APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II L OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
M 20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
N 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) STREET	
O 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 12 23 71 5:10 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
P 22F. HOW DID INJURY OCCUR? Subject passenger in auto/auto collision		Q 21. AUTOPSY? (Yes or No) no	
R I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
S ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Peter Lipkovic, M.D.</i>		T CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
U 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		V 24B. DATE 12/28/1971	
W 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		X 24C. NAME OF CEMETERY OR CREMATORIUM Oaklawn Cemetery	
Y 25B. NAME OF REGISTRAR Robert E. Taber, M.D.		Z 24D. LOCATION (City, town, or county) (State) Baltimore City, MD.	
AA 25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		BB ADDRESS 2525 Fleet St.	



1 E-363 71 12043 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12043

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Natalie Edwards

2. DATE Known  Month 12 Day 23 Year 71 Hour M.  
OF DEATH Estimated

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED  
48 Md. General Hospital 1/16/72

3. DATE Month 12 Day 23 Year 71 Hour  
PRONOUNCED DEAD

6. SEX female 7. RACE Negro 8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

9. DATE OF BIRTH 10. AGE (In years  
6-8-1931 lost birthday) 40 If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counselor, Metropolitan Baltimore

14B. KIND OF BUSINESS OR INDUSTRY No 17. SOCIAL SECURITY NO. 212-2-4443

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

13. FATHER'S NAME Nat Ailor

15. MOTHER'S MAIDEN NAME Mildred Smith

18. INFORMANT Mildred Smith Ailor, 1031 Tiffany Ct.

ADDRESS

19. E965X

CAUSE OF DEATH

Gunshot wound of chest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.) Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12 23-71 1454

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT WORK  NOT WHILE AT WORK

Subject stabbed by unknown assailant  
Subject shot by unknown assailant

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

*S. Lippkovic*  
Peter Lippkovic, M.D.

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

12/24/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE 12-28-71 24C. NAME OF CEMETERY or CREMATORIUM Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

25B. NAME OF REGISTRAR Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Kenneth Law, 4611 Park Heights Ave.

1-6-72 - Letter from - Office of the Chief Medical Examiner, Peter Lipkovic, M.D.  
Assistant Medical Examiner

HRS

XX

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L L -

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced dead was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

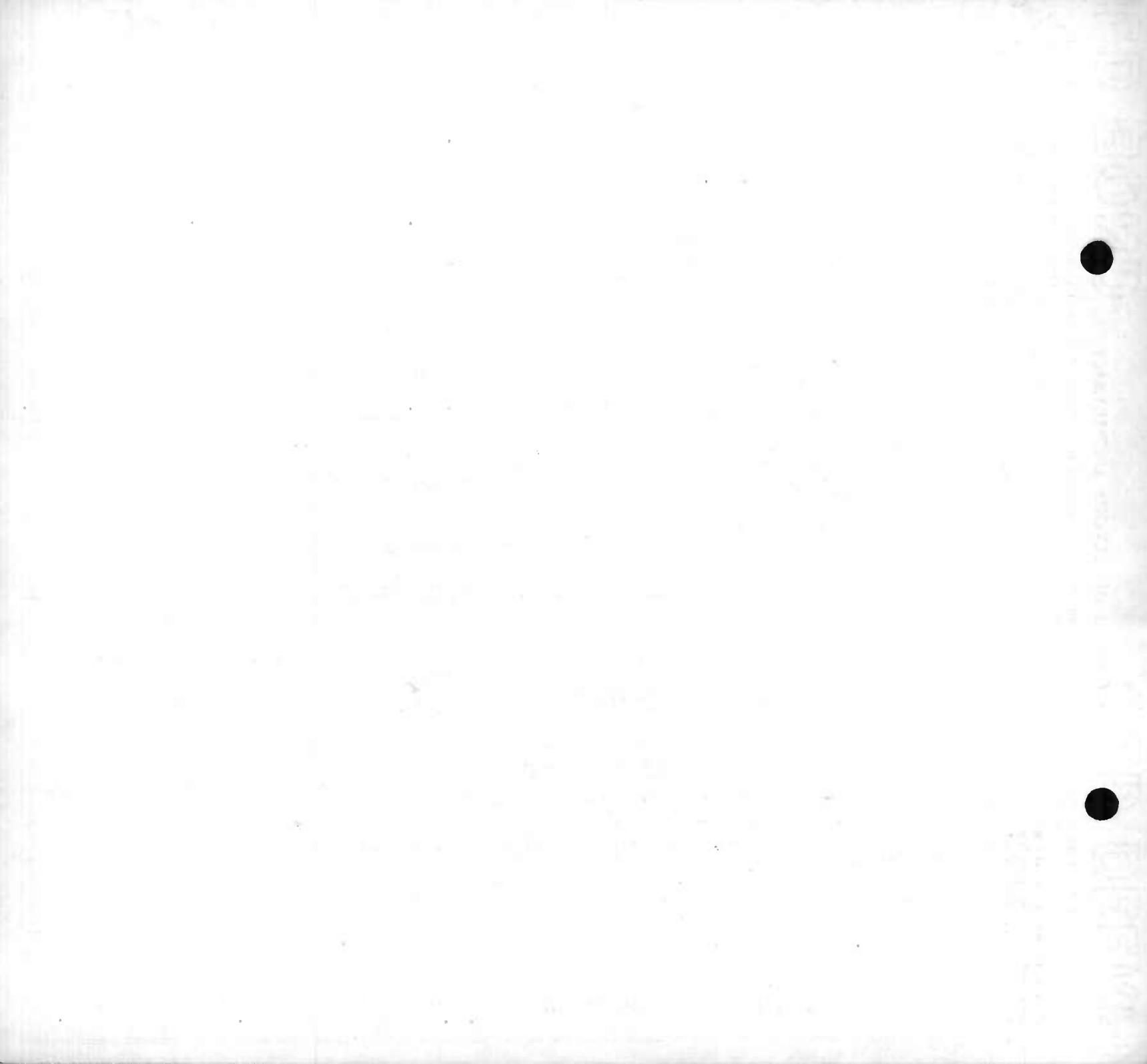
L-340 71 12044		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12044	
BIRTH NO.				2. DATE AND HOUR OF DEATH 12/19/71 9:40AM M.	
1. NAME OF DECEASED (Type or Print) <b>LITTLE, CHARLES P.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>JOHNS HOPKINS HOSPITAL</b>	
				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>804</b>	
				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2103 E. FEDERAL ST</b>	
5. SEX male		6. RACE negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
				8. DATE OF BIRTH <b>06/29/08</b>	
				9. AGE (In years lost birthday) <b>63</b>	
				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steelworker</b>	
				10B. KIND OF BUSINESS OR INDUSTRY	
				11. BIRTHPLACE (State or foreign country) <b>Rockingham, N.C.</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME  <b>Covington, Sally</b>				14. MOTHER'S MAIDEN NAME  <b>Little, JOHN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII 33 Sent 42-14 Oct 42</b>		16. SOCIAL SECURITY NO. <b>577 05 2328</b>		17. INFORMANT  <b>Mary Little, 2103 E. Federal Street</b>	
				ADDRESS	
18. <b>444.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osphenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH  (A) IMMEDIATE CAUSE <b>Ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>acute ventricular insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Embolus to heart</b> (D) <b>Overdose</b>	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b>	
				(B) <b>acute ventricular insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Embolus to heart</b> (D) <b>Overdose</b>	
				(C) <b>Embolus to heart</b> (D) <b>Overdose</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				attribution 2° <b>HASCVD</b> <b>Many years</b>	
MEDICAL CERTIFICATION  19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>Walter Mally MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/19/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>DRR, WALTER M. MALLY</b>		23D. ADDRESS  <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/71</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>Carver Mem. Park</b>	
				24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
				(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Ronald E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Kenneth Law</b>	
				ADDRESS <b>4611 Park Heights Ave.</b>	
VS 150-REV. 1/1/68					

EX. A.

**FUNERAL DIRECTOR: IMPORTANT**

C 516  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
71 12045		CERTIFICATE OF DEATH		71 12045	
1. NAME OF DECEASED (Type or Print)		Chambers		2. DATE AND HOUR OF DEATH	
Genevieve				12-26-71 8 <sup>AM</sup>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE	B. COUNTY
Edgewood N. H.		90		Md.	1202
5. SEX		6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
F		W	8-2-1894	9. AGE (in years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Robert C. Boone		Catherine		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		220-44-1170		Mrs. C. Leo Civish 1301 Southview Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		ADDRESS	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Myocardial Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C.V. Dis.			
(C) Arteriosclerosis		-			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/26/71				✓	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____ that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/26/71 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (did not) view the body after death.				11/30 1971 to 12/26 1971	
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Anthony F. Carozza MD		Degree		12/27/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Anthony F. Carozza		5217 York Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORIAL	
Burial		12-28-71		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGULAR ACCT.		25C. FUNERAL DIRECTOR	
DEC 29 1971				H.W. Jenkins Sons Co. 4905 York Rd.	
				ADDRESS Baltimore, Maryland 21212	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 12046</u>
BIRTH NO. <b>71 12046</b>		2. DATE AND HOUR OF DEATH Dec. 27, 1971		<u>5:20 P.M.</u>
1. NAME OF DECEASED (Type or Print) Caroline K. Jurgens		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  <b>90 Long Green Nursing Home</b>		A. STATE <u>Maryland</u> B. COUNTY <u>2759</u>		
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-1897</b>	9. AGE (in years lost birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Mattes</b>		14. MOTHER'S MAIDEN NAME <b>Clara M. Zander</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-6832</b>	17. INFORMANT <b>Mr. Richard Jurgens</b>	ADDRESS <b>Same</b>
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH <i>Arteriosclerotic heart disease 6 mos</i>		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis generalized 2 yrs</i>		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov 5 69</b> to <b>12/27 1971</b> that (I) <del>last</del> last saw the deceased alive on <b>12/26 1971</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) did not view the body after death.				
23A. SIGNATURE  <i>Norman R. Freeman</i>		Attending Phys. <input checked="" type="checkbox"/> Degree	Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <b>12/29/71</b>
23C. PHYSICIAN'S NAME (Type)  <b>Dr. Norman R. Freeman</b>		23D. ADDRESS  <b>11 W. 29th Street</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-71</b>	24C. NAME of CEMETERY or CREMATORIUM <b>Moreland Memorial Park</b>	24D. LOCATION (City, town, or county) <b>Balto., Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Violet E. Sabey, R.D.</b>	25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>	ADDRESS <b>4905 York Road Balt., Md. 21212</b>

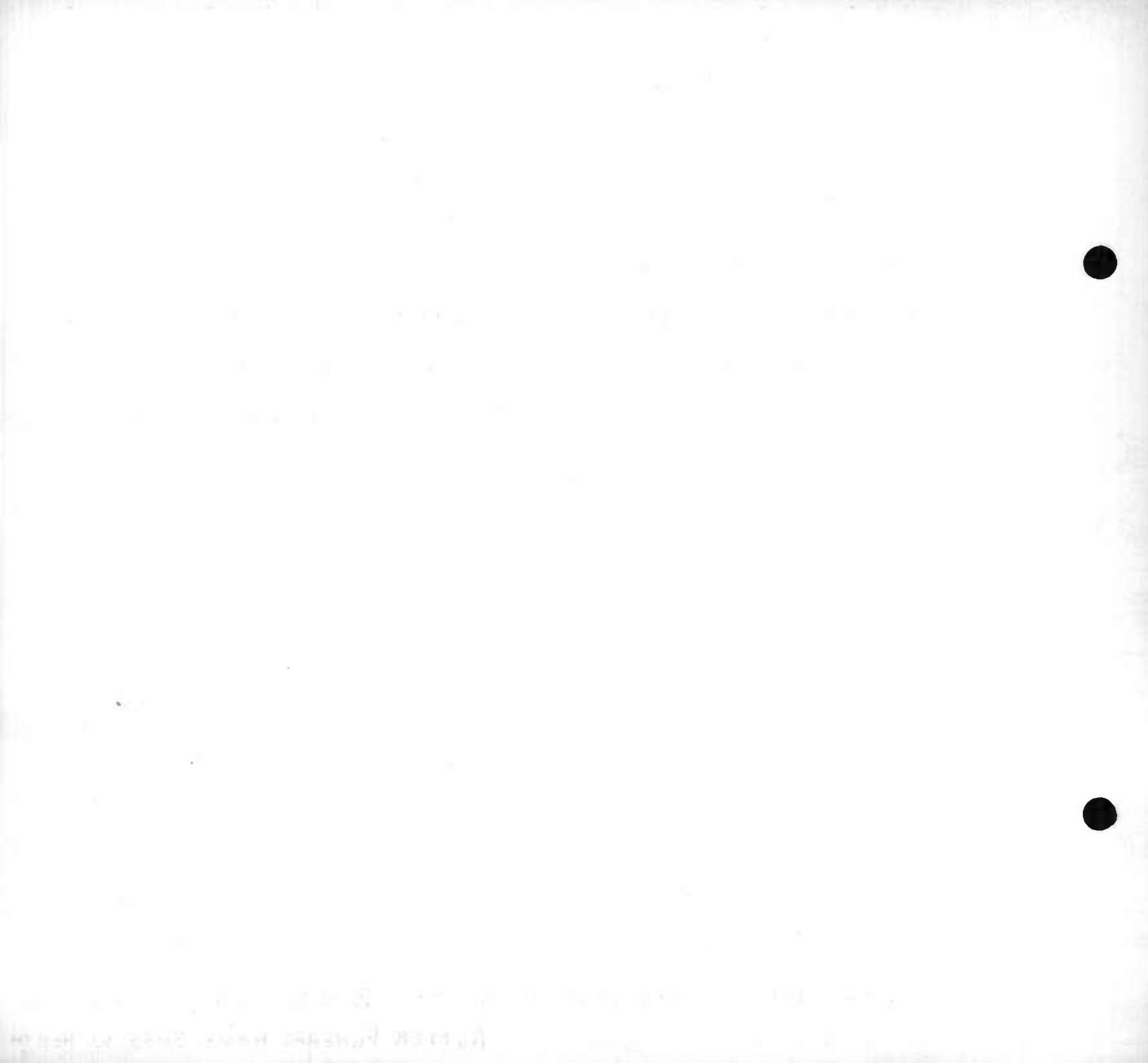
1962-1963  
SCHOOL YEAR



**FUNERAL DIRECTOR: IMPORTANT**

C 600  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 12047		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 71 12047	
1. NAME OF DECEASED (Type or Print) <b>CURRY, LOLA</b>		2. DATE AND HOUR OF DEATH <b>12-29-1971 at 1:15 a.m.</b>			
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD  <b>Lutheran Hospital of Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  <b>MARYLAND BALTD 5300</b>			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>4b</b>		C. CITY OR TOWN  <b>Baltimore</b>		D. INSIDE CITY LIMITS?  <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
E. STREET AND NUMBER  <b>3424 DAYTA Dr.</b>					
5. SEX  <b>Female</b>	6. RACE  <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  <b>4-21-1894</b>	9. AGE (in years less birthday)  <b>77 yrs.</b>	11. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  <b>HOMEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY  <b>HOME</b>		11. BIRTHPLACE (State or foreign country)  <b>SOUTH CAROLINA</b>	
13. FATHER'S NAME  <b>WILLIAM MACH</b>		14. MOTHER'S MAIDEN NAME  <b>CARRIE ?</b>		12. CITIZEN OF WHAT COUNTRY?  <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  <b>No</b>	16. SOCIAL SECURITY NO.  <b>439901</b>	17. INFORMANT  <b>MRS. MAE F. MOODY</b>		ADDRESS  <b>3424 DAYTA DR.</b>	
18. CAUSE OF DEATH  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE  <b>Congestive Cardiac Failure.</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:  <b>Acute Abdomen.</b>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION  <b>12-29-1971</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  <b>None</b>	20A. AUTOPSY? (Yes or No)  <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  <b>No</b>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  <b>None</b>	21C. WHERE DID INJURY OCCUR?  <b>None</b>	(If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour)  <b>12-29-1971</b>	21E. INJURY OCCURRED  <b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b>	21F. HOW DID INJURY OCCUR?  <b>None</b>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>J. Sampat</b>		23B. DEGREE  <b>M.D.</b>	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23C. DATE SIGNED  <b>12-29-1971</b>	
23C. PHYSICIAN'S NAME (Type)  <b>J. SAMPAT</b>	23D. ADDRESS  <b>Lutheran Hospital of Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)  <b>BURIAL</b>	24B. DATE  <b>1-4-71</b>	24C. NAME of CEMETERY or Crematory  <b>ARUBUTUS MEM. Pk.</b>	24D. LOCATION (City, town, or county)  <b>BALTD. Co.; MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT.  <b>DEC 29 1971</b>	25B. NAME OF REGISTRAR  <b>Robert E. Faber, M.D.</b>	25C. FUNERAL DIRECTOR  <b>NUTTER FUNERAL HOME 3035 W. NORTH</b>	ADDRESS		
VS 150-REV. 1/1/68					



FUNERAL DIRECTOR: IMPORTANT

P420  
 71 12048  
 BIRTH NO.  
 1. NAME OF DECEASED  
 (Type or Print) **THOMAS POLLACK SR.**  
 2. DATE AND HOUR OF DEATH  
 12/29/71 3:10 A.M.  
 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**LUTHERAN HOSPITAL, BALTIMORE,  
 MD 21216.**  
 4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)  
 A. STATE **MD**  
 B. COUNTY **1608**  
 C. CITY OR TOWN **BALTIMORE**  
 D. INSIDE CITY LIMITS?  
 YES  NO   
 E. STREET AND NUMBER **3800 ROKEBY RD.**

5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-19-19</b>		9. AGE (in years last birthday) <b>52.</b>		10. If Under 1 Yr. Months Days Hours Min.	
(10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)) <b>ENGINEER.</b>		(10B. KIND OF BUSINESS OR INDUSTRY) <b>Board of Education</b>		11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>					
13. FATHER'S NAME <b>John Pollack</b>		14. MOTHER'S MAIDEN NAME <b>MARY Williams</b>		15. ADDRESS							
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		17. SOCIAL SECURITY NO. <b>215-05-8692</b>		18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <b>BRONCHIOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF:						10 months.	
				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				(C) _____							
19. MEDICAL CERTIFICATION		20A. DATE OF OPERATION <b>12/28/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>To Visualise Extent of Bron. Ca</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
		21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
		22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
		23A. SIGNATURE 		23B. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.		23C. DATE SIGNED <b>12/29/71</b>					
23C. PHYSICIAN'S NAME (Type) <b>AZAD CADER</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL, BALTO, MD 21216</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-3-72</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>WESTERN STAR Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore County, Maryland</b>				(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>		25C. FUNERAL DIRECTOR, ADDRESS <b>HERBERT E. NUTTER Funeral Home 3035 W North Ave</b>							
VS 150-REV. 1/76											

0.9031

## FUNERAL DIRECTOR: IMPORTANT

M 2501

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 12049		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12049	
1. NAME OF DECEASED (Type or Print) MASON, JOSEPH		2. DATE AND HOUR OF DEATH 12-23-71 6:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY		2716	
42 SINAI HOSP. of BALTIMORE, Inc.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-11-08	
13. FATHER'S NAME James Mason		11. BIRTHPLACE (State or foreign country) Md.		9. AGE (In years lost birthday) 63	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Metabolic Acidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) during the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  Chronic Renal Failure		See yes.	
(C) Hypertensive Heart disease		(D) Diabetes Mellitus		See yes.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(E) PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		(F) WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-26 1971 to 12-23 1971 that (I) (we) last saw the deceased alive on 12-23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Veneranda C. Gerasmio, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-23-71	
23C. PHYSICIAN'S NAME (Type) VENERANDA C. GERASMO, M.D.		23D. ADDRESS Sinai Hosp. of Balt., Inc.			
24A. BURIAL/CREMATION, 24B. DATE REMOVAL (Specify) Burial 12-29-71		24C. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem.		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971 Robert E. Lester, M.D.		25B. NAME OF REGISTRAR V. Bailey		25C. FUNERAL DIRECTOR Kelson F.H. 1348 Calhoun Street	
VS 150-REV. NO. 48B					



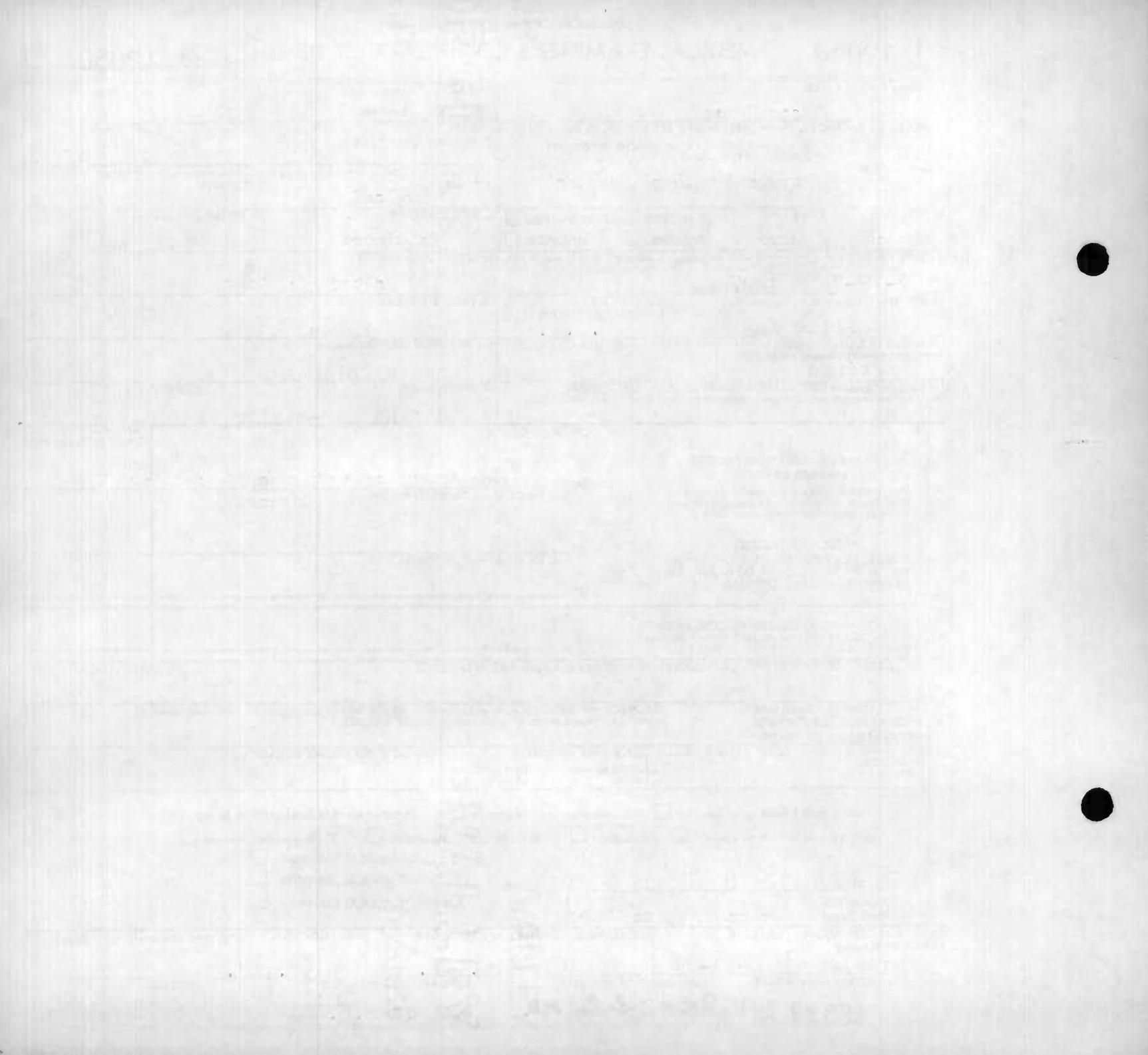
H 520  
71 12050  
BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12050

1. NAME OF DECEASED (Type or Print)		Isaac Hymes		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 27	Year 71	Hnur 8:25 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD	Estimated <input type="checkbox"/>	Month 12	Day 27	Year 71	Hour 8:25 P.M.
		Maryland General Hospital							
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 7-12-04		10. AGE (in years last birthday) 67	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 608 Waltermeyer Court					
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Thomas Hymes						
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Amanda Coleman						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	18. INFORMANT Sadie Hughes-sister 2436 Linden Ave.						
19. 41391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT m. WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 12-28-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	24C. NAME OF CEMETERY or CREMATORIAL Arbutus Mem. Pk.		24D. LOCATION Balto., Md.		(City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Tauber, M.D.		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street			



**FUNERAL DIRECTOR: IMPORTANT**

M 620  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12051		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12051	
1. NAME OF DECEASED (Type or Print)		VERNON MORRIS		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 12/27/71 5:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND GENERAL HOSPITAL 48 GOLD ST.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1501			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME Solomon Morris		14. MOTHER'S MAIDEN NAME Pauline Wash		E. STREET AND NUMBER 604 GOLD ST.		F. UNDER 1 Yr. Months Days Hours If Under 24 Hrs. Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218016727		17. INFORMANT Onnie Morris		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. 59901 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: STAPH. SEPTICEMIA				ADDRESS 1531 Woodyear St.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) URINARY TRACT INFECTION DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		LEGTHOWERHOB PNEUMONIA					
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  SALVATORE R. DONOHUE MD		Attending Phys. <input type="checkbox"/> DEGREE		Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/28/71	
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE MD		23D. ADDRESS MARYLAND GEN. HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR Geo. J. Kelen		ADDRESS 1348 Calhoun St.	
VS 150-REV. 1/1/68							

4

3

## BALTIMORE CITY HEALTH DEPARTMENT

S 535  
71 12052

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12052

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lawrence Snowden

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

## 6. SEX

Male

## 7. RACE

Negro

## 8. MARRIED

 NEVER MARRIED WIDOWED DIVORCED2. DATE  
OF  
DEATHKnown  Month 12 Day 27 Year 71 Hour 3:20 P.M.  
Estimated 3. DATE  
PRONOUNCED DEAD

Month 12 Day 27 Year 71 Hour 3:20 P.M.

## 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

## A. STATE

Maryland

## B. COUNTY

1501

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES  NO 

## 9. DATE OF BIRTH

12-17-15

10. AGE (In years  
lost birthday)

56

## If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

## E. STREET AND NUMBER

1529 Woodyear Street

## 13. FATHER'S NAME

Elmer Snowden

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

## 14B. KIND OF BUSINESS OR INDUSTRY

(If yes, give war or dates of service)

## 15. MOTHER'S MAIDEN NAME

Mable Carter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

214105586

## 18. INFORMANT

Mable Dare

## ADDRESS

same

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## 19.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT  
m. WORK  NOT WHILE  
AT WORK 

## 22F. HOW DID INJURY OCCUR?

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-28-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

12-31-71

## 24C. NAME of CEMETERY or CREMATORIUM

Arbutus Mem. Pk.

## 24D. LOCATION (City, town, or county) (State)

Balto., Md.

## 25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971

## 25B. NAME OF REGISTRAR

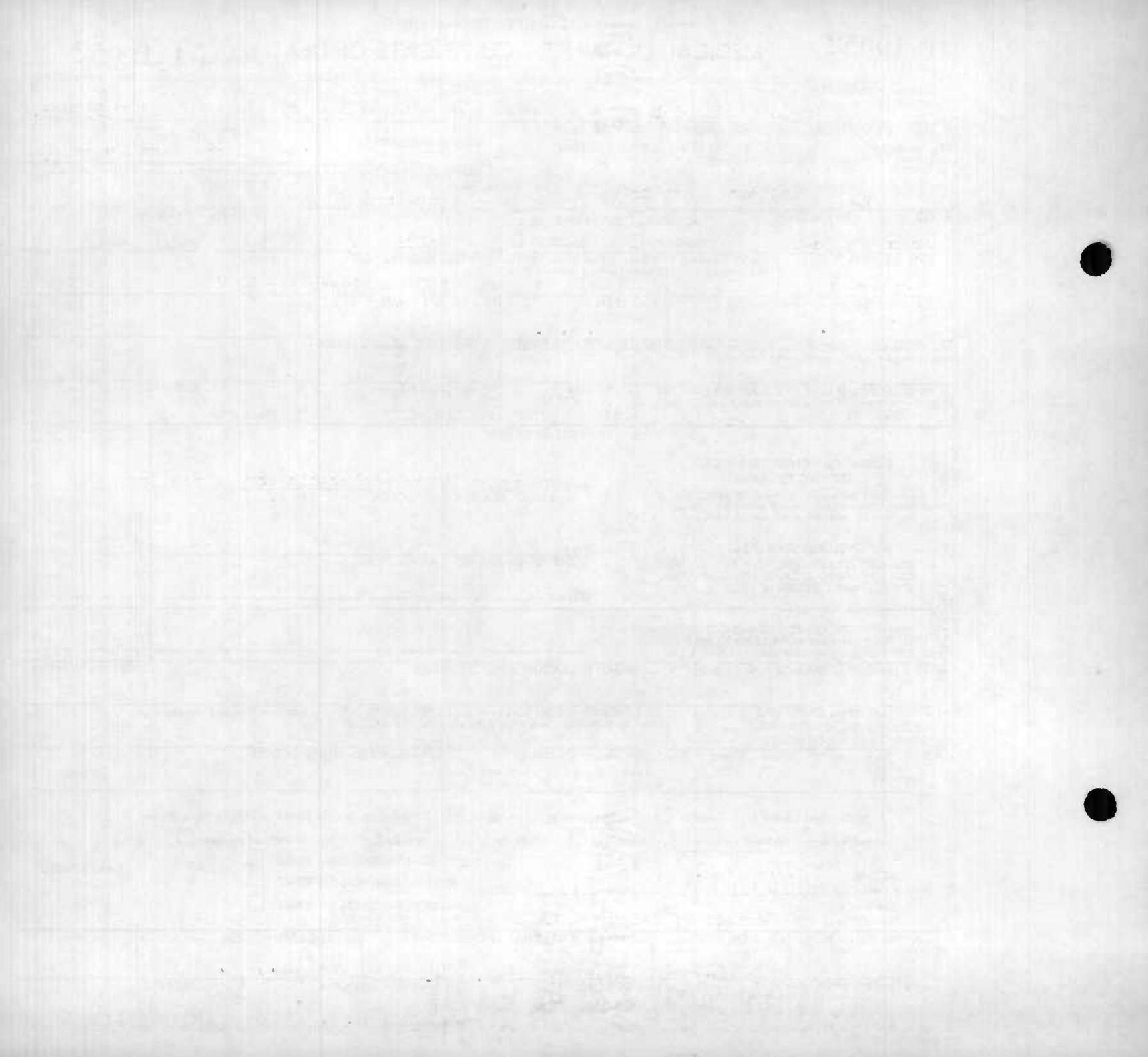
Robert E. Barber, M.D.

## 25C. FUNERAL DIRECTOR

V. Bailey

## ADDRESS

Kelson F.H. 1348 Calhoun Street



**FUNERAL DIRECTOR: IMPORTANT**

S 512  
 71 12053  
 BIRTH NO.  
 1. NAME OF DECEASED  
 (Type or Print)  
**SIMPSON, DENNIS**  
 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**Veterans Administration Hospital  
23 3900 Loch Raven Boulevard  
Baltimore, Maryland 21218**

This certificate must be approved by the chief medical examiner or his assistant or his assistant or his medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 71 12053

2. DATE AND HOUR OF DEATH

12/27/71

7:35 A

A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN **Baltimore**

E. STREET AND NUMBER **921 Whitlog Road**

D. INSIDE CITY LIMITS?

YES

NO

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

**Machine operator Heating plant**

13. FATHER'S NAME

**Edward Simpson**

15. Was Deceased Ever in U. S. Armed Forces?  
 (Yes, no or unknown) (If yes, give war or dates of service)

**Yes 1/17/44 - 1/20/46**

16. SOCIAL SECURITY NO.

**212-09-6106**

8. DATE OF BIRTH

**1/6/08**

9. AGE (In years  
 last birthday) **63**

If Under 1 Yr.  
 Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

**Spartanburg, S.C.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

14. MOTHER'S MAIDEN NAME

**Addie Brutton**

18. CAUSE OF DEATH

**450X1  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH**

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

17. INFORMANT **Pulmonary emboli**  
 DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
 BETWEEN ONSET AND DEATH  
**MINUTES**

(B) \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

19A. DATE OF OPERATION **19B. CONDITION FOR WHICH OPERATION  
 WAS PERFORMED** 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED  
 IN CERTIFYING CAUSES OF DEATH? **YES**

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?

While At Work  Not While At Work

22. I certify that **1** (this hospital) attended the deceased from **December 13th 1971** to **December 27th 1971**, that **1** (we) last saw the deceased alive on **December 27th 1971** and that in **1** (our) opinion death occurred on the date and hour and from the causes stated above. **1** (We) (did) **not** view the body after death.

23A. SIGNATURE **Meyer R. Heyman M.D.** 23B. DATE SIGNED **December 28, 1971**

23C. PHYSICIAN'S NAME (Type) **MEYER R. HEYMAN M.D.** 23D. ADDRESS **3900 Loch Raven Boulevard  
Baltimore, Maryland 21218**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Dec 28, 1971** 24C. NAME OF CEMETERY OR CREMATORIUM **Gettysburg Natl** 24D. LOCATION (City, town, or county) (State) **Gettysburg Pa.**

25A. DATE REC'D BY HEALTH DEPT. **DEC 29 1971** 25B. NAME OF REGISTRAR **Robert E. Barber, M.D.** 25C. FUNERAL DIRECTOR **Williams Funeral Home 319 N. Belvidere St.** ADDRESS

924 WHITELOCK ST

## BALTIMORE CITY HEALTH DEPARTMENT

M 320  
71 12054

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. /1 12054

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William E. Mathews

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
38 University Hospital

6. SEX

male

7. RACE

Negro

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 2. DATE  
OF  
DEATHKnown  Month 12  
Estimated  Day 24  
Year 71  
Hour M.3. DATE  
PRONOUNCED DEADMonth 12  
Day 24  
Year 71  
Hour 11:30 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

Md.

B. COUNTY

1801

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES  NO 

E. STREET AND NUMBER

113 N. Poppelton St.

9. DATE OF BIRTH

Dec. 24, 1893

10. AGE (In years  
lost birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Laurel Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry Mathews

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Elevator Operator

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAREN NAME

Mattie ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-0417594

18. INFORMANT

Anne Mathews

ADDRESS

113 N. Poppelton St.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19. CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

ANTECEDENT CAUSES

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/25/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORIUM

24D. LOCATION (City, town or county) (State)

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

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Burial

12/30/71

Mt. Calvary Cemetery

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Cremation

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Burial

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary Cemetery

Towson, Md.

Burial

12/30/71

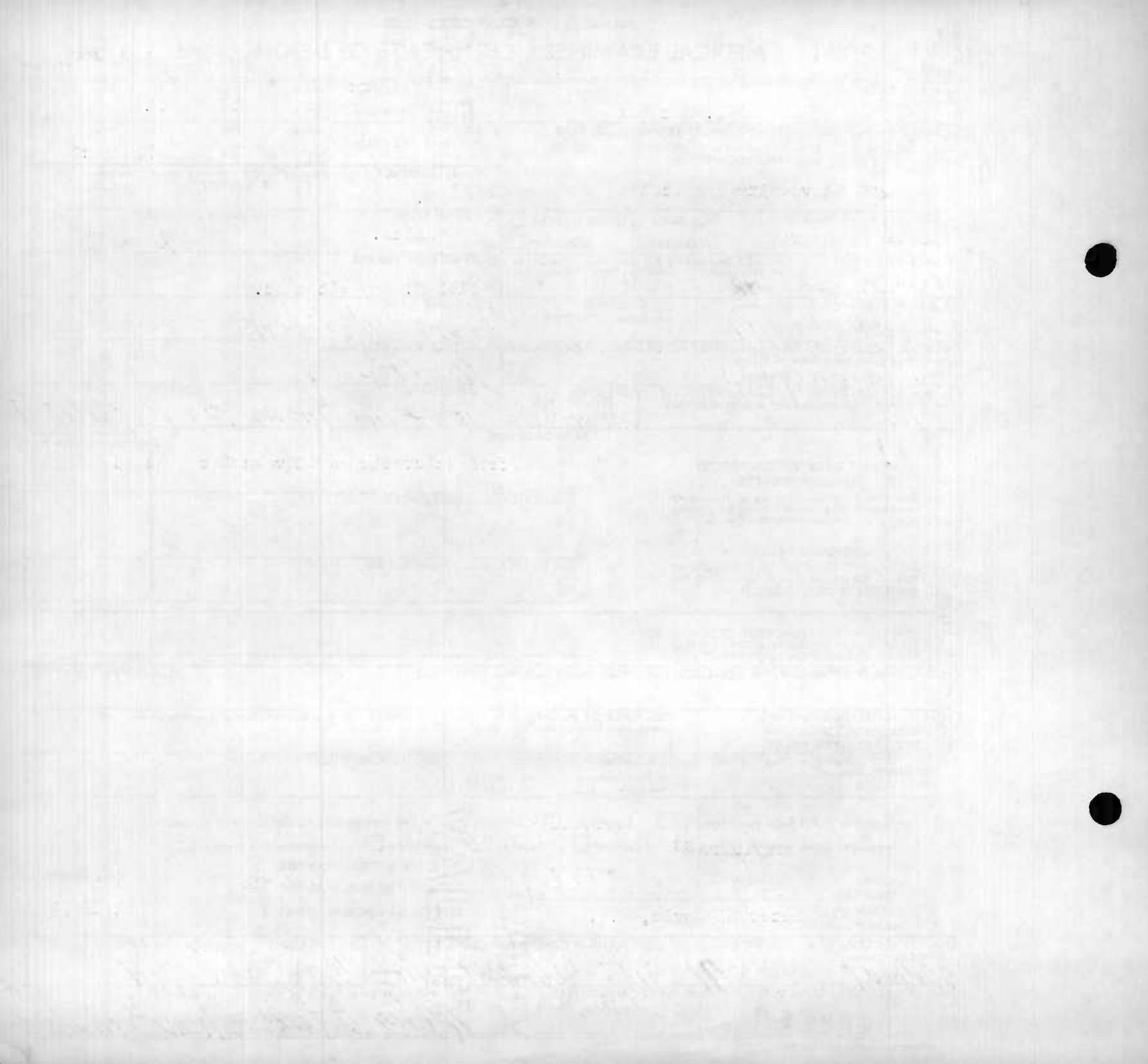
Mt. Calvary Cemetery

Towson, Md.

Cremation

12/30/71

Mt. Calvary



## BALTIMORE CITY HEALTH DEPARTMENT

H 400  
71. 12055

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12055

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Carrie Hill

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*OO*(If not in hospital or institution, give street  
address or location)

2824 Clifton Avenue

## 6. SEX

female

## 7. RACE

Negro

8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 2. DATE  
OF  
DEATHKnown Estimated 

Month

Day

Year

Hour

12

23

71

4:50 p.m.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

12

23

71

4:50 p.m.

## 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

1547

## C. CITY OR TOWN

Balto.

## D. INSIDE CITY LIMITS?

YES NO 

## E. STREET AND NUMBER

2824 Clifton Avenue

## 9. DATE OF BIRTH

July 11, 1881

10. AGE (In years  
lost birthday)

90

## 11. BIRTHPLACE (State or foreign country)

*MD*12. CITIZEN OF  
WHAT COUNTRY?

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

## 14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

## 17. SOCIAL SECURITY NO.

## 18. INFORMANT

Son of Smith 408 Normandy Ave.

## ADDRESS

## 15. MOTHER'S MAIDEN NAME

Louise

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## 19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

No

## 22A. EXTERNAL CAUSE WAS

UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

## 22E. INJURY OCCURRED

## 22F. HOW DID INJURY OCCUR?

WHILE AT  
m, WORK  NOT WHILE  
AT WORK 

## 23.

I certify that I held on Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE*Peter Lipkovic, M.D.*EXAMINER'S  
NAME (Type)CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

## DATE SIGNED

12/24/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

## 24B. DATE

## 24C. NAME of CEMETERY / CREMATORIUM

## 24D. LOCATION (City, town, or county) (State)

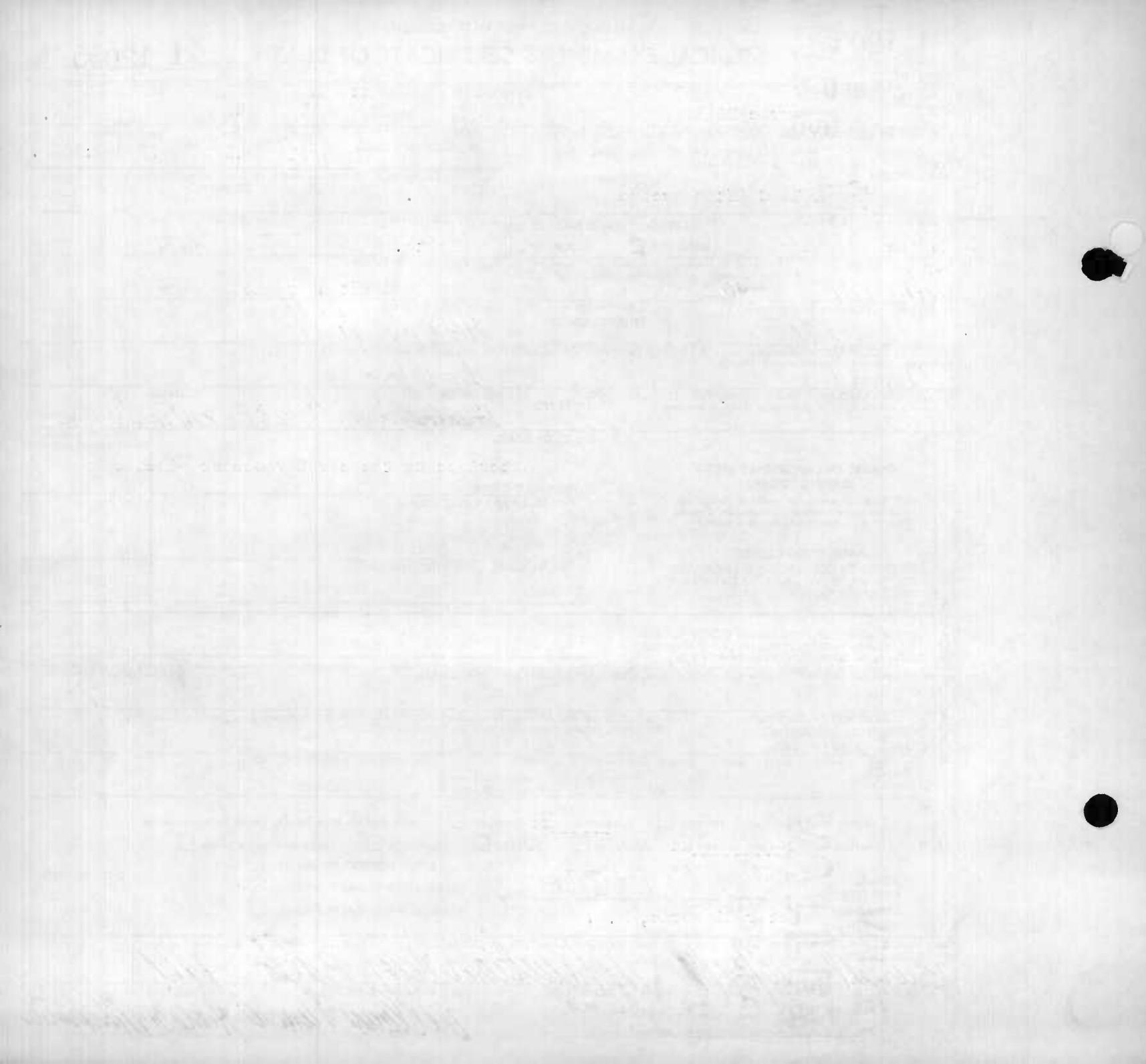
## 25A. DATE REC'D BY HEALTH DEPT.

## 25B. NAME OF REGISTRAR

DEC 29 1971 Robert E. Gaber, M.D.

## 25C. FUNERAL DIRECTOR

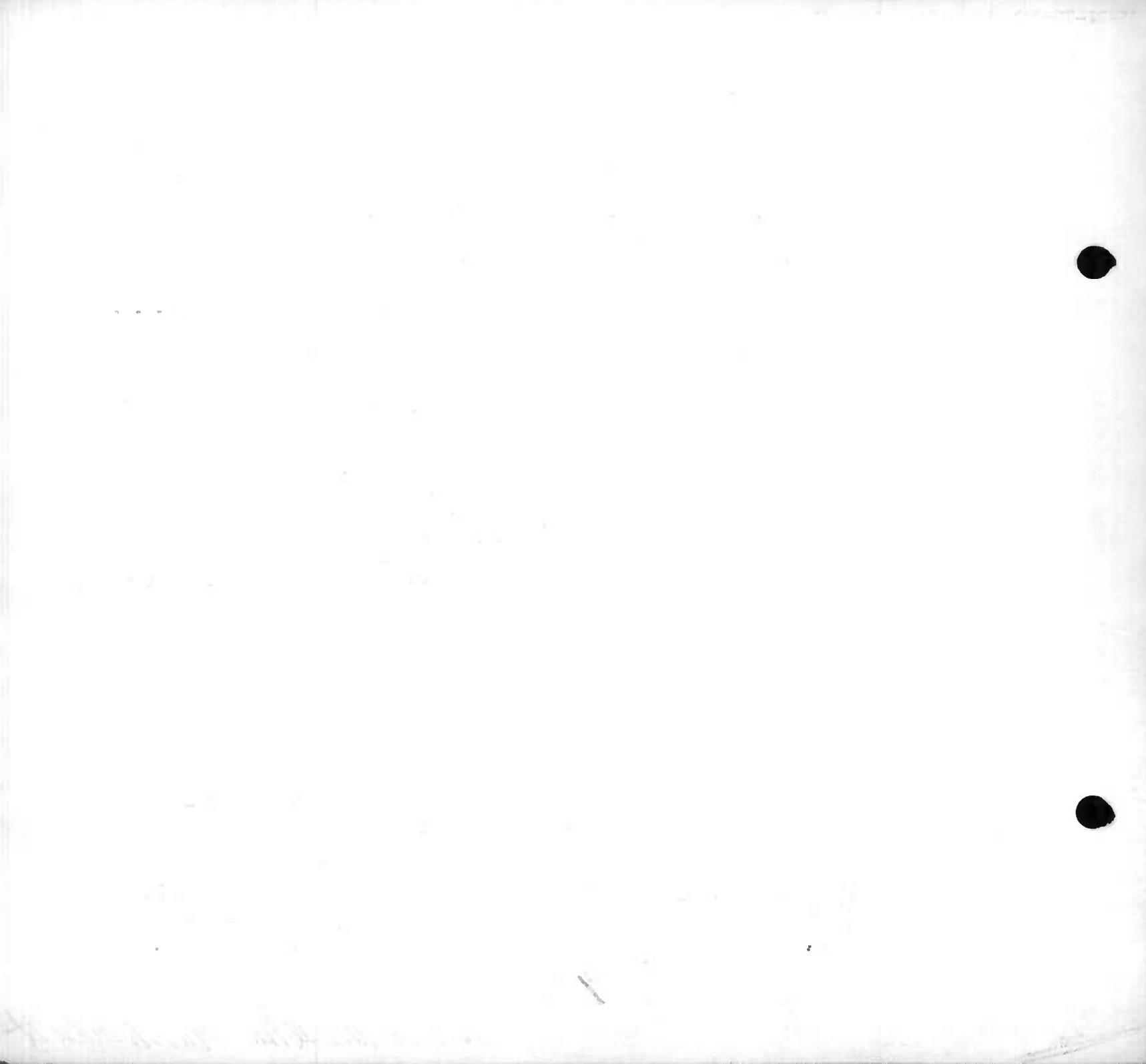
ADDRESS  
William Funeral Home 3199 McHenry St.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
71 12056		CERTIFICATE OF DEATH		71 12056	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BENS, ASYINA		12 23 / 71		10 30 A.M.	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Maryland			
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-19-1921 9. AGE (in years lost birthday) 50	
13. FATHER'S NAME James Powell		11. BIRTHPLACE (State or foreign country) Maryland, Balt/o		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service  No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Verdell Smith	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  Ca of Breast. + Metastatic to liver, lung, liver + bone			
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-18-19 71 to 12-23-19 71 that (I) (we) last saw the deceased alive on 12-23-19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Wisneski		M.D. DEGREE		23B. DATE SIGNED 12/23/71	
23C. PHYSICIAN'S NAME (Type) J. Wisneski		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/71		24C. NAME OF CEMETERY OR CREMATORIAL	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Tabel, M.D.		24D. LOCATION City, town, or county) (State) Beltsville, Md.	
25C. FUNERAL DIRECTOR Williams Funeral Home 3997 Frederick St		ADDRESS			



## BALTIMORE CITY HEALTH DEPARTMENT

71 12057

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12057

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER JAMES HALL

(Type or Print)

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
ADDRESS OR LOCATIONCERTIFICATE AMENDMENT  
1023 N. Wolfe St.

1-13-72

2. DATE Known  Month Day Year Hour  
OF DEATH Estimated 3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 26 1971 4:15 p.m.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
STATE Md. B. COUNTY 808

5. CITY OR TOWN Balto.

D. INSIDE CITY LIMITS?  
YES  NO 6. SEX male 7. RACE negro 8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 9. DATE OF BIRTH 10. AGE (In years  
lost birthday) 19 If Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) Detroit Mich. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

14A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Laborer 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Edna McClenden

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 214-36-3165 18. INFORMANT Mrs Rebecca Saunders, 1316 Chester

ADDRESS

19. 485X1 CAUSE OF DEATH Acute bronchopneumonia  
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
complicating intravenous narcotism(A) IMMEDIATE CAUSE Intravenous narcotism  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

20. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT m. NOT WHILE AT WORK

22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinionresulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL SIGNATURE *R.S. Fisher* M.D. CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER  DATE SIGNED 12-27-71

24A. BURIAL CREMATION, REINTERMENT (Specify) 24B. DATE 12/31/71 24C. NAME OF CEMETERY or CREMATORIUM MT Calvary Cemetery 24D. LOCATION (City, town, or county) (State) A A County Md

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR DEC 29 1971 Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR Adolphus Halstead ADDRESS 1206 W north Ave

VS 151-REV. 1/1/68

1-13-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

1-26-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

b

805

## BALTIMORE CITY HEALTH DEPARTMENT

G 255  
71 12058

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12058

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NAAMAH GOSSMAN (Grossman)

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3819 Ridgewood Ave.

6. SEX

female

7. RACE

negro

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

9. DATE OF BIRTH

4/28/50

10. AGE (In years  
lost birthday)

21

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

M's Deborah Nutter, 540 McMechen S

2. DATE Known  Month Doy Year Hour  
OF DEATH Estimated  M.3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 26 1971 1 P M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY 1402C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS?  
YES  NO 

E. STREET AND NUMBER 540 Mechen St.

13. FATHER'S NAME James Grossman

15. MOTHER'S MAIDEN NAME Dorothy

19. 304.9 I

CAUSE OF DEATH Intravenous narcotism APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A)

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) WHILE AT WORK  NOT WHILE AT WORK 

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type) Russell S. Fisher, M.D.CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-27-71

24A. BURIAL CREMATION, 24B. DATE  
REMOVAL (Specify) 12/30/71 24C. NAME OF CEMETERY or CREMATORIUM  
Burial Mt Calvary Cemetery24D. LOCATION (City, town, or county) (State)  
A A County Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Dec 29 1971 Robert E. Farber, M.D. Adolphus Halstead 1206 W North Ave

2-10-1972 - Completion of cause of death on a pending medical examiner death certificate

Russell S. Fisher, M.D.

HRS

Z-100

71 12059

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12059  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARK ZEPP

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
So. Balto. General Hospital

6. SEX

male

7. RACE

white

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

9. DATE OF BIRTH

Nov 26 1957

10. AGE (In years  
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

none

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

15. MOTHER'S MAIDEN NAME

Janet A Zepp

18. INFORMANT

Janet A Zepp

ADDRESS  
as above

19.

E9881 X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

Cranio-cerebral injuries

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

4400 blk. 6th St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

12-25-71 1:01 a.m.

22E. INJURY OCCURRED

WHILE AT WORK NOT WHILE AT WORK 

22F. HOW DID INJURY OCCUR?

Unknown-probably  
beaten or hit by auto.

23.

I certify that I held an Inquiry  Inspection  Autopsy   
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-27-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/30/71

24C. NAME OF CEMETERY or CREMATORIUM

Glen Haven Cemetery

24D. LOCATION

(City, town, or county) (State)

Glen Burnie Md, AACo Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1971 Robert E. Vassar, M.D.

25B. NAME OF REGISTRAR

Robert E. Vassar, M.D.

25C. FUNERAL DIRECTOR

McGilly Funeral Home 237 Patapsco Ave 21225

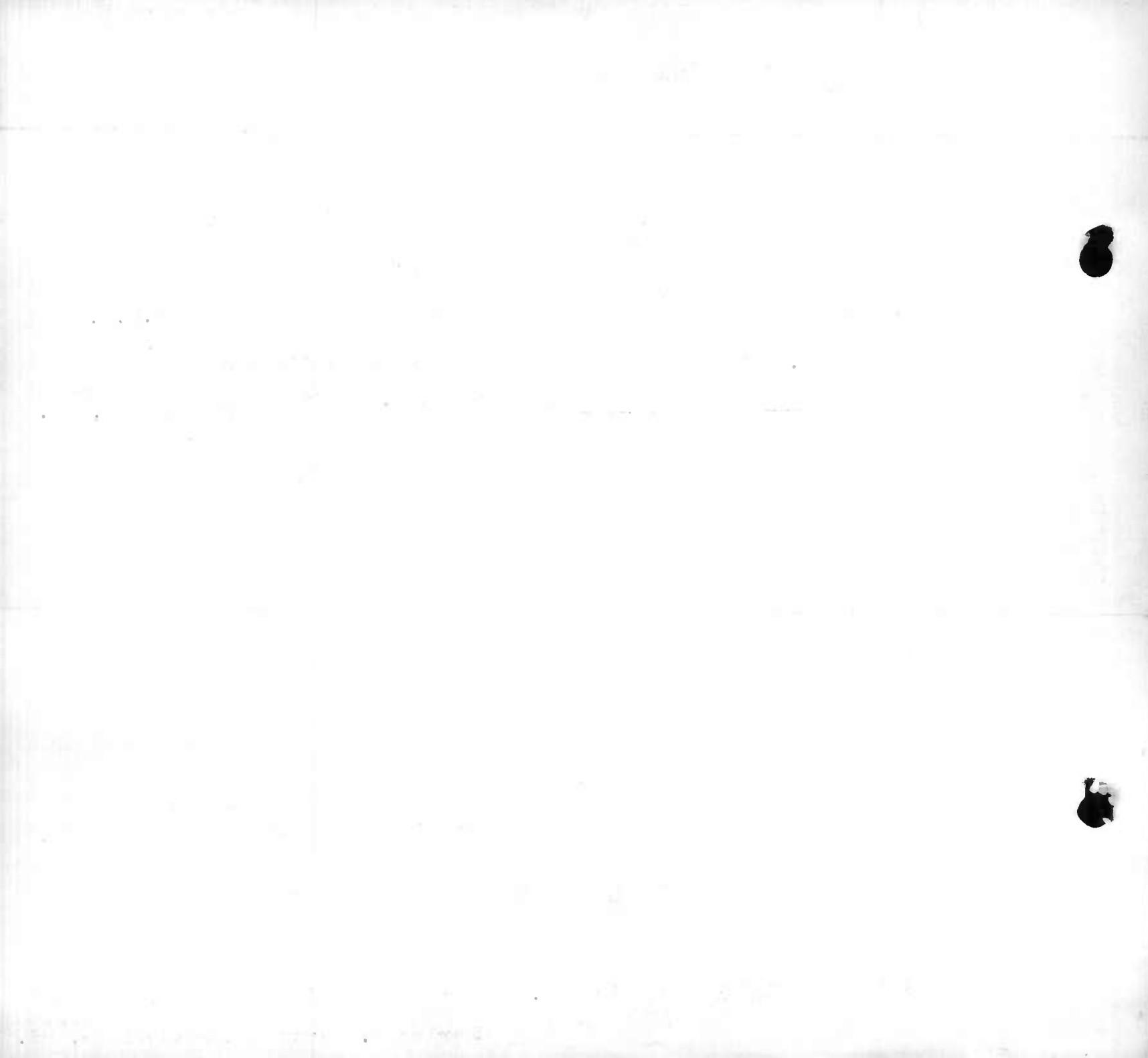
1-11-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D. (dt)  
Chief Medical Examiner

HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

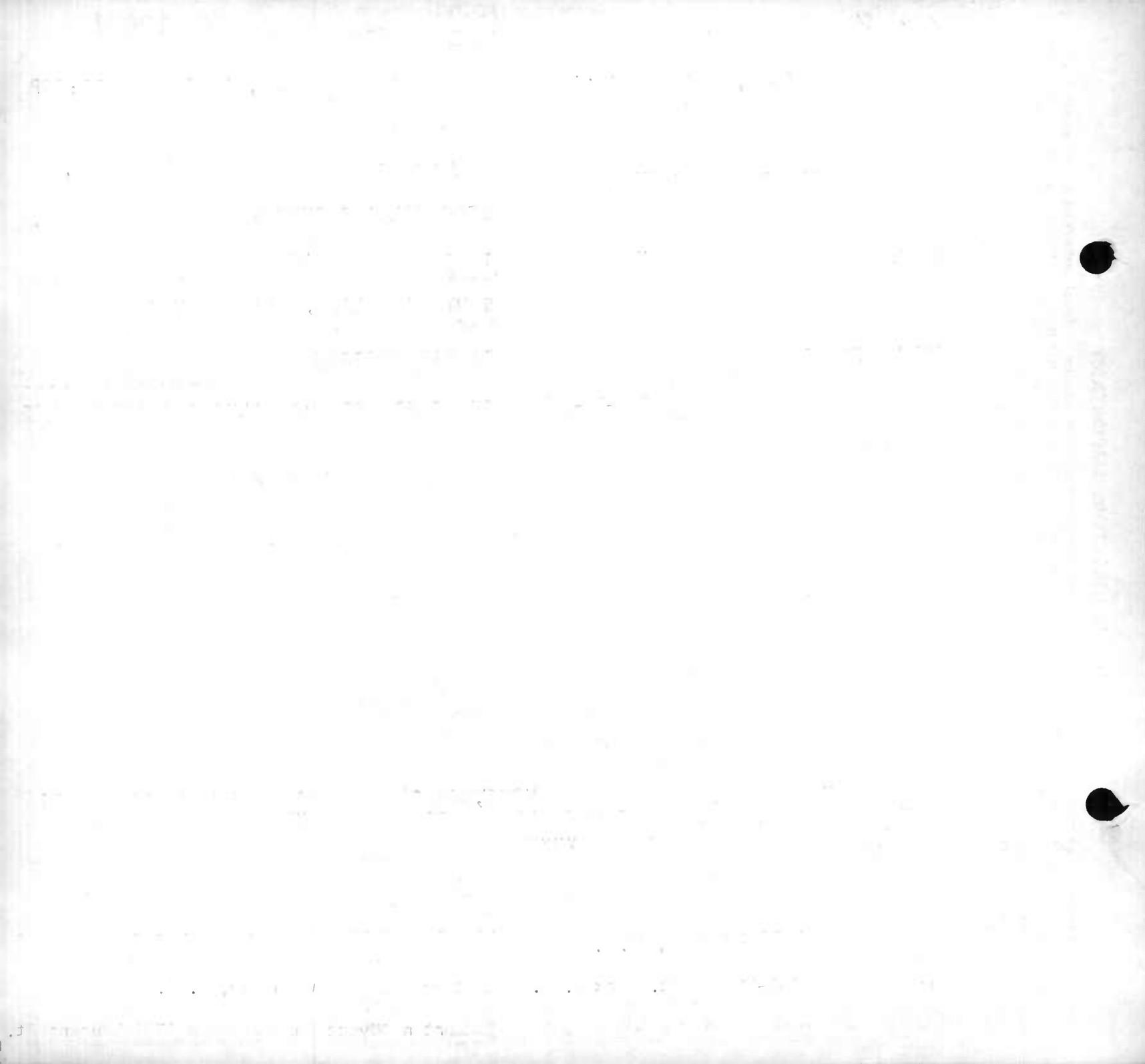
W-614		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12060	
BIRTH NO. 71 12060					
1. NAME OF DECEASED (Type or Print) Sarah Jane Warfield		2. DATE AND HOUR OF DEATH 12/27/71 5:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  478 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY Harford 6200			
FULL NAME OF HOSPITAL OR INSTITUTION  478 Maryland General Hospital		C. CITY OR TOWN Forest Hill		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER Box 56 Jarrettsville Road					
5. SEX F	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-17	9. AGE (in years last birthday) 54	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas M. Fender		14. MOTHER'S MAIDEN NAME Sarah Jane Edwards		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-14-1317		17. INFORMANT Ernest W. Warfield Chair.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  371.1		ADDRESS Box 56 Forest Hill, Md. 21050 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Varicose Veins			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  Gastric Varices			
(C) DUE TO, OR AS A CONSEQUENCE OF:  Hepatic cirrhosis					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROXJ		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/25 to 12/27 1971 that (I) (we) last saw the deceased alive on 12/27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd B. Mandel MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/27/71	
23C. PHYSICIAN'S NAME (Type) Lloyd B. Mandel MD		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME of CEMETERY or CREMATORIUM Bel Air Mem. Gardens	
				24D. LOCATION Bel Air, Harford, Maryland	
25A. DATE REC'D. BY HEALTH DEPT. DEC 29 1971		25B. NAME OF REGISTRAR Robert E. Neary		25C. FUNERAL DIRECTOR Charles E. Kurtz	
				ADDRESS 21084 Jarrettsville, Md.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 12061		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12061	
1. NAME OF DECEASED (Type or Print) TAYLOR, MAGGIE EVANS		2. DATE AND HOUR OF DEATH DECEMBER 27, 1971 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) A. STATE MARYLAND B. COUNTY 2004			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2505 HOLLINS STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 15 22	9. AGE (in years lost birthday) 49	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA, MANNING	
13. FATHER'S NAME IRVIN EVANS		14. MOTHER'S MAIDEN NAME CARRIE BROGGON		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250-30-5516		17. INFORMANT ST AGNES RECORDS WILKENS & CATON AVES ADDRESS BALTIMORE MD 21229	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  I This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic papillary adenocarcinoma  (B) DUE TO, OR AS A CONSEQUENCE OF: primary carcinoma not known  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes.	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from NOVEMBER 24 19 71 to DECEMBER 27 19 71 that (2) (we) last saw the deceased alive on DECEMBER 27 19 71 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE 77Mol		Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 12-20-71.
23C. PHYSICIAN'S NAME (Type) JACOBUS MOI. M.D.		23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-72	24C. NAME OF CEMETERY or CREMATORIAL St. Mark A. M.E Cemetery	24D. LOCATION Clowden Cty, S. C.	(City, town, or county) (State)
25A. DATE REC'D. BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Johnson, M.D.	25C. FUNERAL DIRECTOR Morton E. Dyett	ADDRESS Funeral Home 1701 Laurens St.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>71 12062</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X REG. NO. <u>71 12062</u>	
1. NAME OF DECEASED (Type or Print) <u>Elo GENIE Moore FINNERTAN</u>		2. DATE AND HOUR OF DEATH <u>December 28, 1971 7:40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION Memorial Hospital</u> <u>44</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> S. <u>Harford Co.</u> B. COUNTY <u>Harford Co.</u> C. CITY OR TOWN <u>Belair</u> MD 21014 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> RACE <u>White</u>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH <u>08-12-90</u>		8. AGE (in years lost birthday) <u>81</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Mr Charles Dick</u>		14. MOTHER'S MAIDEN NAME <u>Mrs ELIZABETH McCANN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-6653</u>	
17. INFORMANT (Daughter) <u>Miss FRANCES E. FINNERTAN</u>		18. CAUSE OF DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Cards Respiratory</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> , <u>Brain tumor</u> , <u>fronital</u> ?	
(B) ANTECEDENT CAUSES		(B) IMMEDIATE CAUSE <u>Pneumonia</u> , <u>left</u> <u>Burto.</u>	
(C) DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)	
II 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Sudden	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. MEDICAL CERTIFICATION	
21A. DATE OF OPERATION <u>None</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>?</u>	
21C. AUTOPSY? (Yes or No) <u>No</u>		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>?</u>	
21E. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nonly medical examined) <u>No</u>		21F. WHERE DID INJURY OCCUR? <u>(In Baltimore City, give exact location)</u>	
21G. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21H. INJURY OCCURRED	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR? <u>?</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>10/25/71</u> 19 <u> to 12/28/71</u> 19 <u> that (I) (we) last saw the deceased alive on <u>12/27/71</u> 19<u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.</u></u>			
23A. SIGNATURE <u>Edwin B. Garrett M.D.</u>		23B. DATE SIGNED <u>12/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edwin B. Garrett M.D.</u>		23D. ADDRESS <u>11 East Chase St. City 21202</u>	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <u>Burial Dec.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Southern Methodist Cemetery</u>	
24D. LOCATION <u>Dublin, Harford Co., Maryland</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>DEC 30 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Valley Jr.</u>		25C. FUNERAL DIRECTOR <u>Joseph William Foster</u>	
ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-533 71 12063		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Hattie Benedetta</i>		2. DATE AND HOUR OF DEATH 12/28/71 2:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Ave. Baltimore, Md. 21224  <i>Baltimore City Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE B. COUNTY Maryland Baltimore 5300	
5. SEX Female Caucasian		6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>GEORGE TODD</i>		8. DATE OF BIRTH 3/12/87	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		9. AGE (in years last birthday) 87	
16. SOCIAL SECURITY NO. 216-87-4092		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT BCH Records:		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		14. MOTHER'S MAIDEN NAME <i>Sophia</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 2		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) (Approx.) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1/71 to 12/28/71 that (I) (we) last saw the deceased alive on 12/28/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>S. Scharf</i>	
23B. DATE SIGNED 12-28-71		23C. PHYSICIAN'S NAME (Type) S. Scharf M.D.	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIAL CAMBRIDGE	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Jacobs, M.D.	
25C. FUNERAL DIRECTOR J. P. Connelly 300 Main St.		ADDRESS	



1

P-514 71 12064

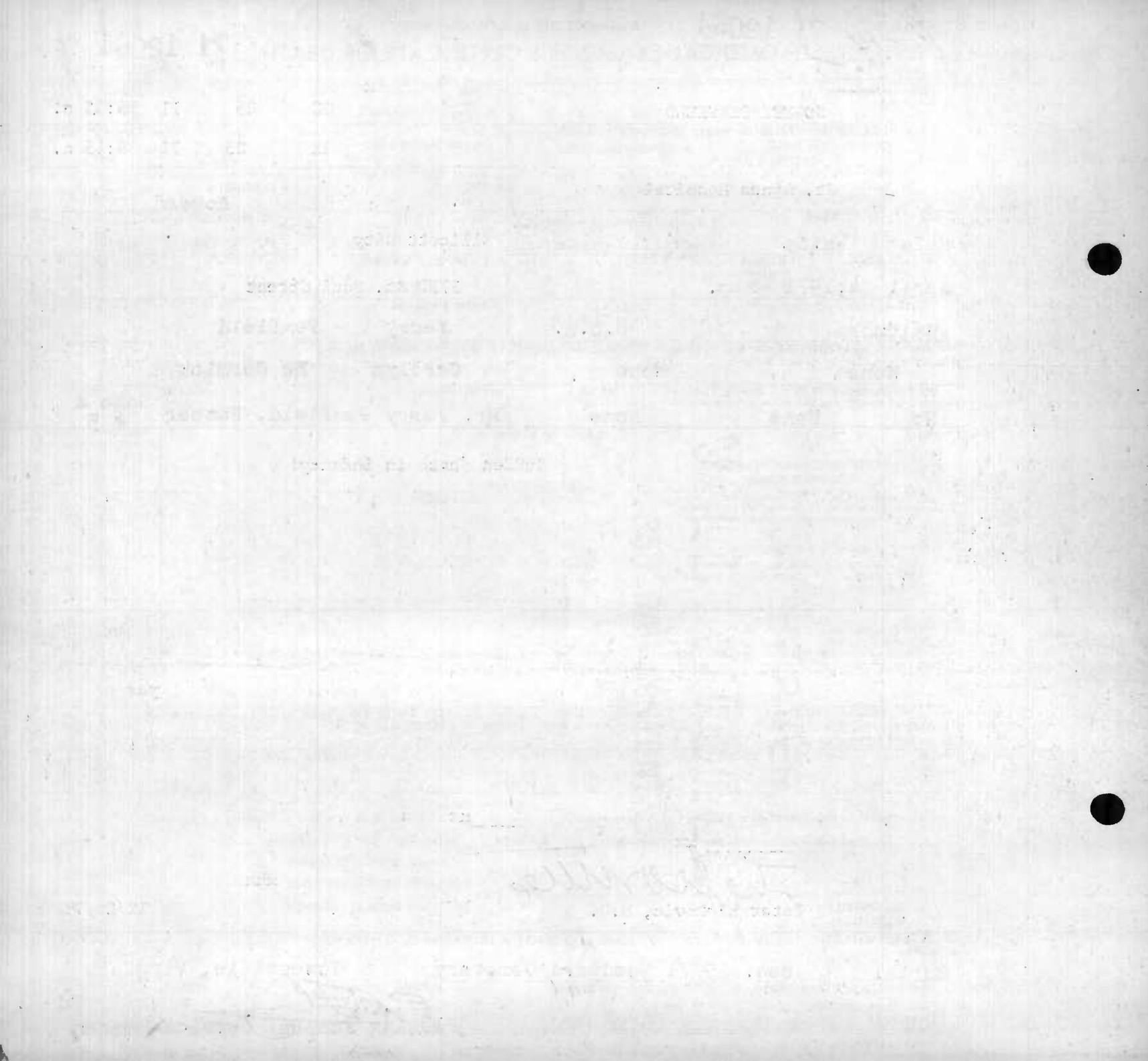
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12064

BIRTH NO. Baltimore Co. Md. REG. NO. \_\_\_\_\_

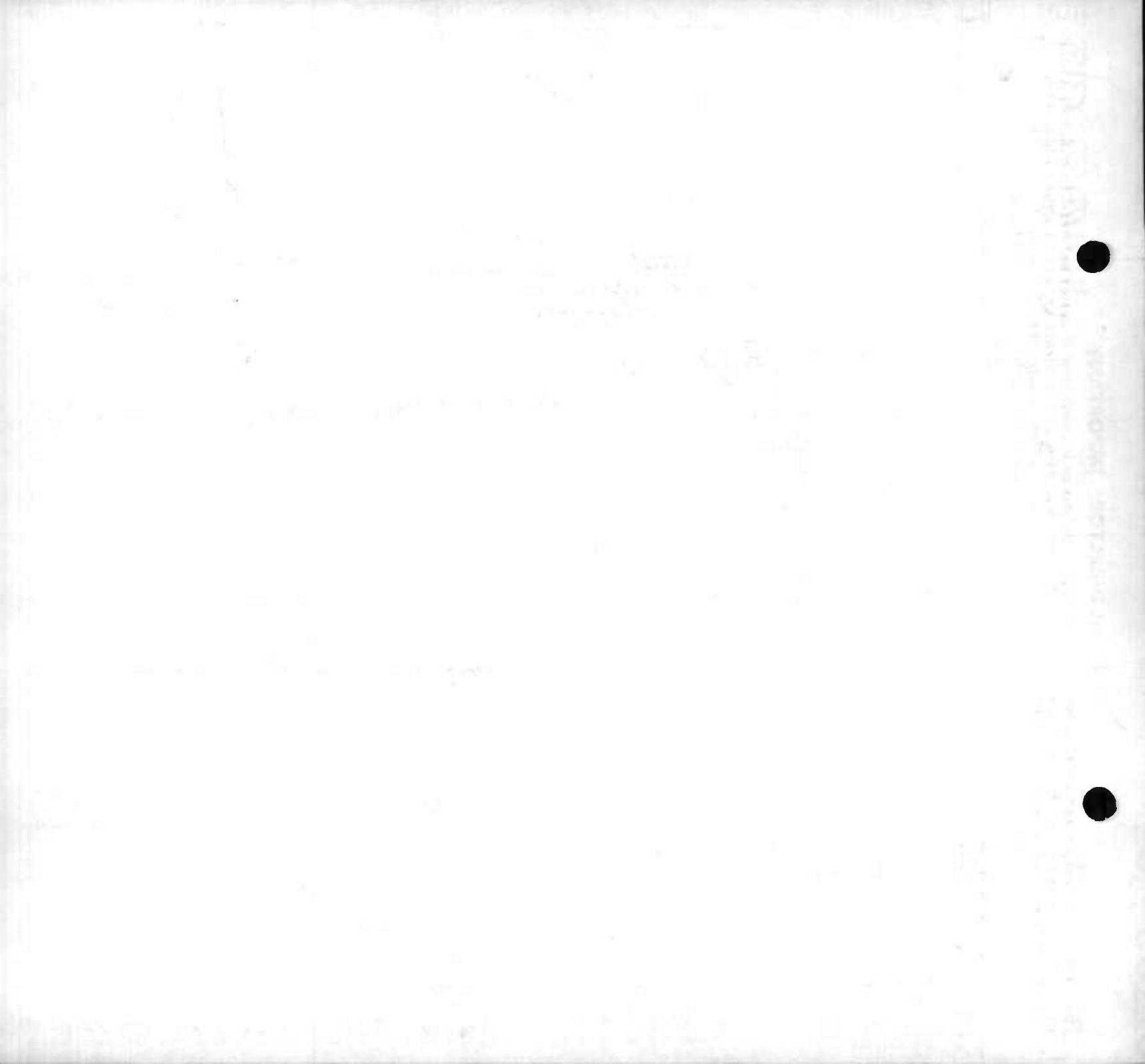
1. NAME OF DECEASED (Type or Print)		SCOTTY PENFIELD		2. DATE Known <input checked="" type="checkbox"/> Month 12 Estimated <input type="checkbox"/> Day 25 Year 71 Hour 9:45 a. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 25 Year 71 Hour 9:45 a. M.
6. SEX <u>Male</u>	7. RACE <u>White</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Howard</u> 6300	
9. DATE OF BIRTH <u>April 24, 1971</u>		10. AGE (In years lost birthday) <u>8 mo.</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	C. CITY OR TOWN <u>Ellicott City</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	E. STREET AND NUMBER <u>3750 St. Paul Street</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	15. MOTHER'S MAIDEN NAME <u>Carolyn Mc Cormick</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		17. SOCIAL SECURITY NO. <u>None</u>	18. INFORMANT <u>Mr. Jerry Penfield, Father</u> ADDRESS <u>Same # 5</u>	
19. <u>795X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <u>1</u>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <u>yes</u>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> m. <input type="checkbox"/>	NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Dec. 29/71</u>	24C. NAME OF CEMETERY or CREMATORIAL <u>Woodward Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Jonesville, Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Fleming, M.P.</u>	25C. FUNERAL DIRECTOR <u>E. B. Fleming</u>	ADDRESS <u>Benson</u> Md	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

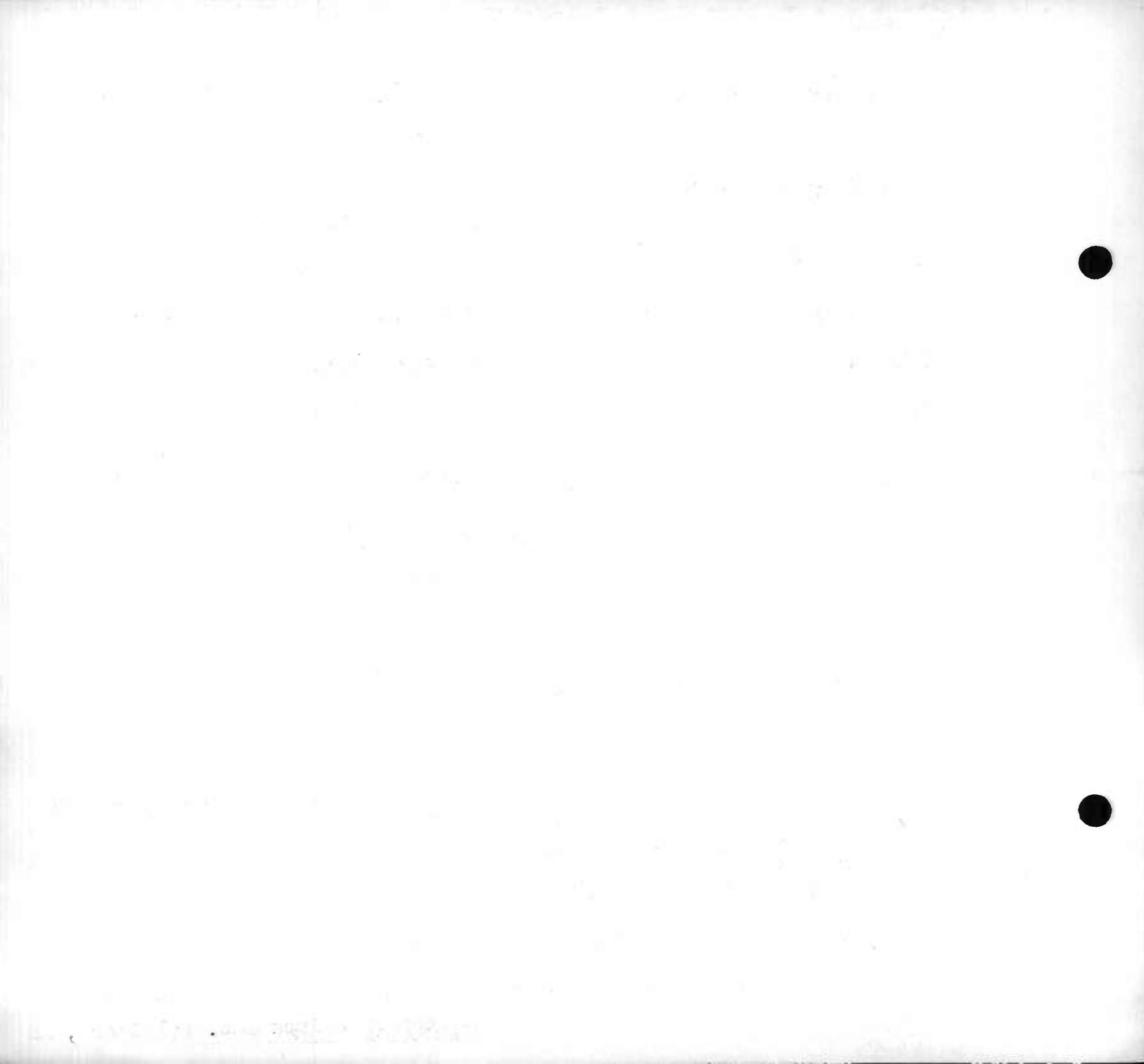
D-630		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12065	
BIRTH NO. 71 12065		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DOHERTY, ROSE M.		2. DATE AND HOUR OF DEATH 12-26-1971 7:20 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hospital</i>		4. USUAL RESIDENCE [Where deceased lived, II institution; residence before admission] A. STATE MD B. COUNTY 2734			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04-21-96 9. AGE (in years lost birthday) 76 75 If Under 1 Yr. Months 8 Days 8 Hours 0 Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Supervisor-Crown Cork & Seal Co.			
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES G. DOHERTY		14. MOTHER'S MAIDEN NAME JANE OWENS?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-8217			
17. INFORMANT Mr. Edward Conroy		ADDRESS 3739 Raspe Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES		CAUSE OF DEATH SEPTICEMIA. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENDI FAILURE.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: HEART FAILURE.			
(C)		(D)			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-16 1971 to 12-26 1971 that (I) (we) last saw the deceased alive on 12-26 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert J. Doherty</i>		MD - DEGREE		23B. DATE SIGNED 12-26-1971	
23C. PHYSICIAN'S NAME (Type) ROBERT J. DOHERTY MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-29-71		24C. NAME OF CEMETERY OR CREMATORIUM MOST HOLY REDEEMER	
24D. LOCATION BALTO., MD.					
25A. DATE REC'D BY HEALTH DEPT. 11/30/1971		25B. NAME OF REGISTRAR Robert E. Parker, M.D.		25C. FUNERAL DIRECTOR J. Walter Conklin	
				ADDRESS 5444 BALAIR RD.	



## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 12066		
1. NAME OF DECEASED (Type or Print) DALLAS POE RANEY		2. DATE AND HOUR OF DEATH DECEMBER 28, 1971 1030 A.M.						
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE ARKANSAS B. COUNTY VOT						
Johns Hopkins Hospital		C. CITY OR TOWN LITTLE ROCK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
5. SEX M 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-07 9. AGE (in years last birthday) 64		If Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10B. KIND OF BUSINESS OR INDUSTRY FINANCE		11. BIRTHPLACE (State or foreign country) NEWARK		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME THOMAS J.		14. MOTHER'S MAIDEN NAME INEZ BRANNON		17. INFORMANT Hy - RELATIVES		ADDRESS		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 7		18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION 12-17-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pelvic Mass		(A) IMMEDIATE CAUSE Septic Shock DUE TO, OR AS A CONSEQUENCE OF:  (B) UNDETERMINED SOURCE DUE TO, OR AS A CONSEQUENCE OF:  (C) LIPOSARCOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr.
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12-01 1971 to 12-28 1971 that (I) (we) last saw the deceased alive on 12-28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE		MD DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 12/29/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Johns Hopkins Hospital						
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/30/71		24C. NAME of CEMETERY or CREMATORIUM Rose Lawn-Mem. Garden		24D. LOCATION Little Rock, ARKANSAS		
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Tandy, M.D.		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.		ADDRESS Baltimore, Md.		
VS 150-REV. 1/1/68								



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12067		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		71 12067	
1. NAME OF DECEASED (Type or Print)		Italo Valsecchi		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH		12/28/71 12 05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  00 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 2734		5. SEX Male		6. RACE White	
4012 Hamilton Ave.				C. CITY OR TOWN Baltimore		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10.2. 1920	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years for birthday) 51		10B. KIND OF BUSINESS OR INDUSTRY Constructual Eng. Federal Govt.		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Italo Valsecchi, Sr.				14. MOTHER'S MAIDEN NAME Ramanzina Onbretta		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219287242		17. INFORMANT Mrs. Catherine Valsecchi Same		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Squamous Cell Carc. noma DUE TO, OR AS A CONSEQUENCE OF: Left Lung.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C).....					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION Oct 29, 1971	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Co surg	20A. AUTOPSY? Yes or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2. 12 1960 to 12. 20 1971, that (I) (we) last saw the deceased alive on 12. 20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/>		Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		5012 Norford Rd. • Bel Air, Md.		12/28/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12 31 71		24C. NAME of CEMETERY or CREMATORIAL DEGREE		24D. LOCATION		(City, town, or county) (State)	
Burial		Cedar Hill Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Valsecchi, M.D.		25C. FUNERAL DIRECTOR		Leonard J. Ruck Inc., Balt. Md.		ADDRESS	
DEC 30 1971								21214	
VS 150-REV. 1/1/68									



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

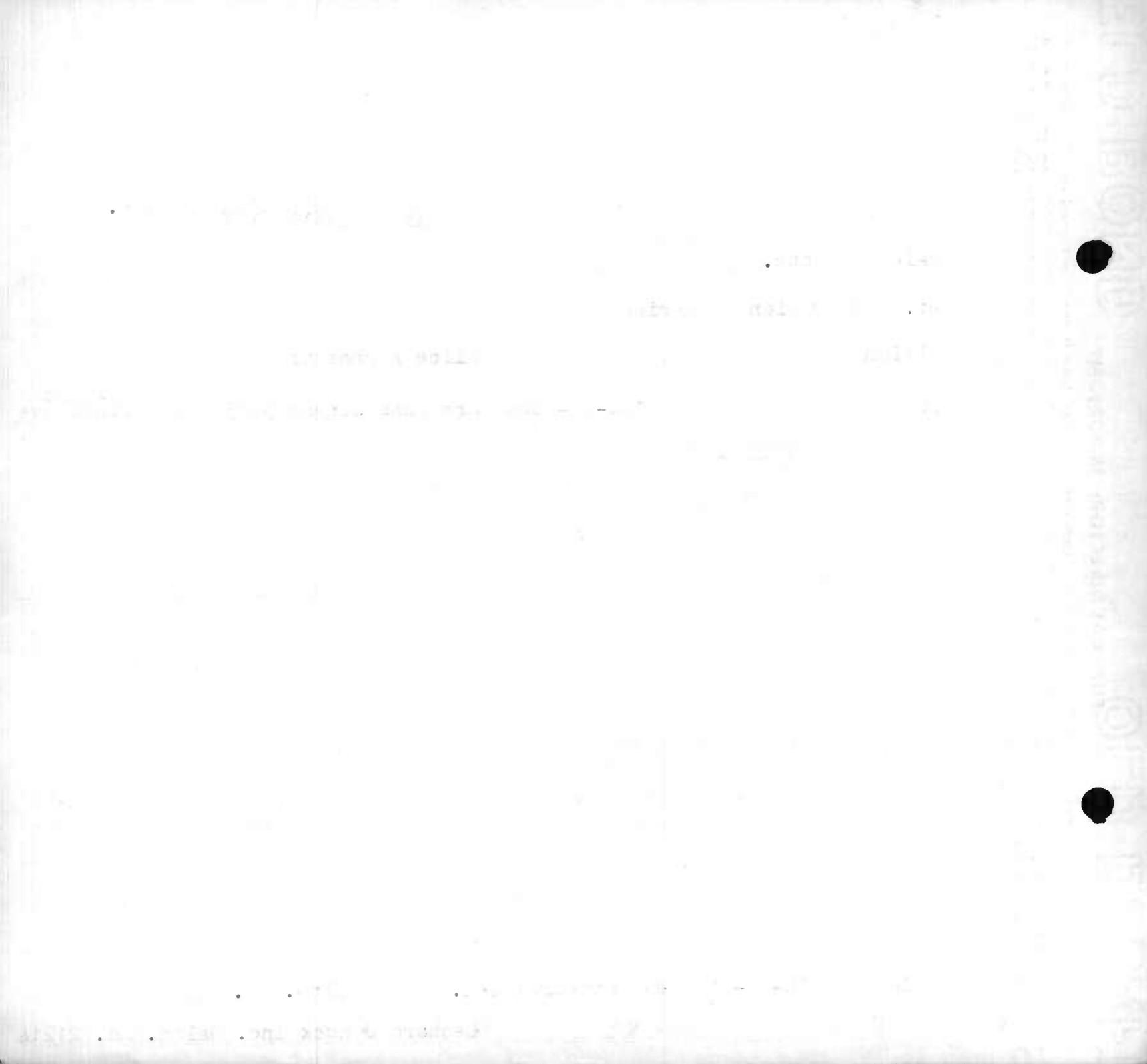
W-425		71 12068	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12068
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH Dec. 28, 1971   1:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 604 Montpelier Street C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION  Keswick Home for Incurables Of Balto. City. 700 W. 40th Street 21211				E. STREET AND NUMBER see above	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1889	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Doe Hill, Virginia	
13. FATHER'S NAME John H. Wilson				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ???	16. SOCIAL SECURITY NO. 217-14-2229			14. MOTHER'S MAIDEN NAME Martha Jane Siple	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(B) DUE TO, OR AS A CONSEQUENCE OF Pulmonary Embolus Osseous		11 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) 15 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3 Aug 1971 to 28 Dec 1971, and that (I) (we) last saw the deceased alive on 28 Dec 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Guy Homer				23B. DATE SIGNED 28 Dec 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/30/71	24C. NAME of CEMETERY or CREMATORIUM Parkwood		24D. LOCATION (City, town, or county) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
ADDRESS Leonard J Ruck Inc. Baltimore, Md					

and with printed

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12069		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12069					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH									
WILLIAM H. TAYLOR		DECEMBER 28, 71 8: 10 A. M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2706		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
5. SEX Male		6. RACE Cauca.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-21-01		9. AGE (In years lost birthday) 70		If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Electrician		10B. KIND OF BUSINESS OR INDUSTRY Marine		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William ROBERT TAYLOR		14. MOTHER'S MAIDEN NAME Alice A Phoebus									
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 64-03-3026A		17. INFORMANT Mrs Anna Schemm		ADDRESS 21206 Belle Vista Ave					
18. 4409 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF:									
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last.		(B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) ARTERIOSCLEROSIS									
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1426 19 71 to 1428 19 71 that (I) (we) last saw the deceased alive on 12/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/28/71							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 33rd and Velvet St.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-30-71		24C. NAME of CEMETERY or CREMATORIAL New Cathedral Cem.		24D. LOCATION Balto. Md.		ICity, town, or county) (State)			
Burial		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Farley Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md. 21214			



**FUNERAL DIRECTOR: IMPORTANT**

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P-362 71 12070

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X REG. NO.

71 12070

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH ELIZABETH PATTERSON

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street  
address or location)

UNIVERSITY OF MARYLAND HOSPITAL

38

5. SEX

F

6. RACE

N

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]

LABORER

13. FATHER'S NAME

CHARLES MARIN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sibling the UNDERLYING CONDITION (last).

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

FEB. 1969

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

BREAST

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Indify medical examiner)

21B. PLACE OF INJURY (e.g. in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
(Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work

Not While  
At Work

22. I certify that (I) (this hospital) attended the deceased from 12/21/71 19 to 12/23/71 19  
that (I) (we) last saw the deceased alive on 12/23/71 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

I. Wexler

M.D.  
DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

12/23/71

23C. PHYSICIAN'S  
NAME (Type)

I. WEXLER M.D.  
DEGREE

23D. ADDRESS

BALTIMORE, MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12/29/71

24C. NAME OF CEMETERY OR CREMATORIY

CHRIST Rock

24D. LOCATION  
(City, town, or county)

Rockfor. MD. (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1971

25B. NAME OF REGISTRAR

Ruth E. Miller

25C. FUNERAL DIRECTOR

Alberto Q. Dixie

ADDRESS

CAMBRIDGE, MD.

19. *Leucosia* *leucostoma* *leucostoma* *leucostoma*

**FUNERAL DIRECTOR: IMPORTANT**

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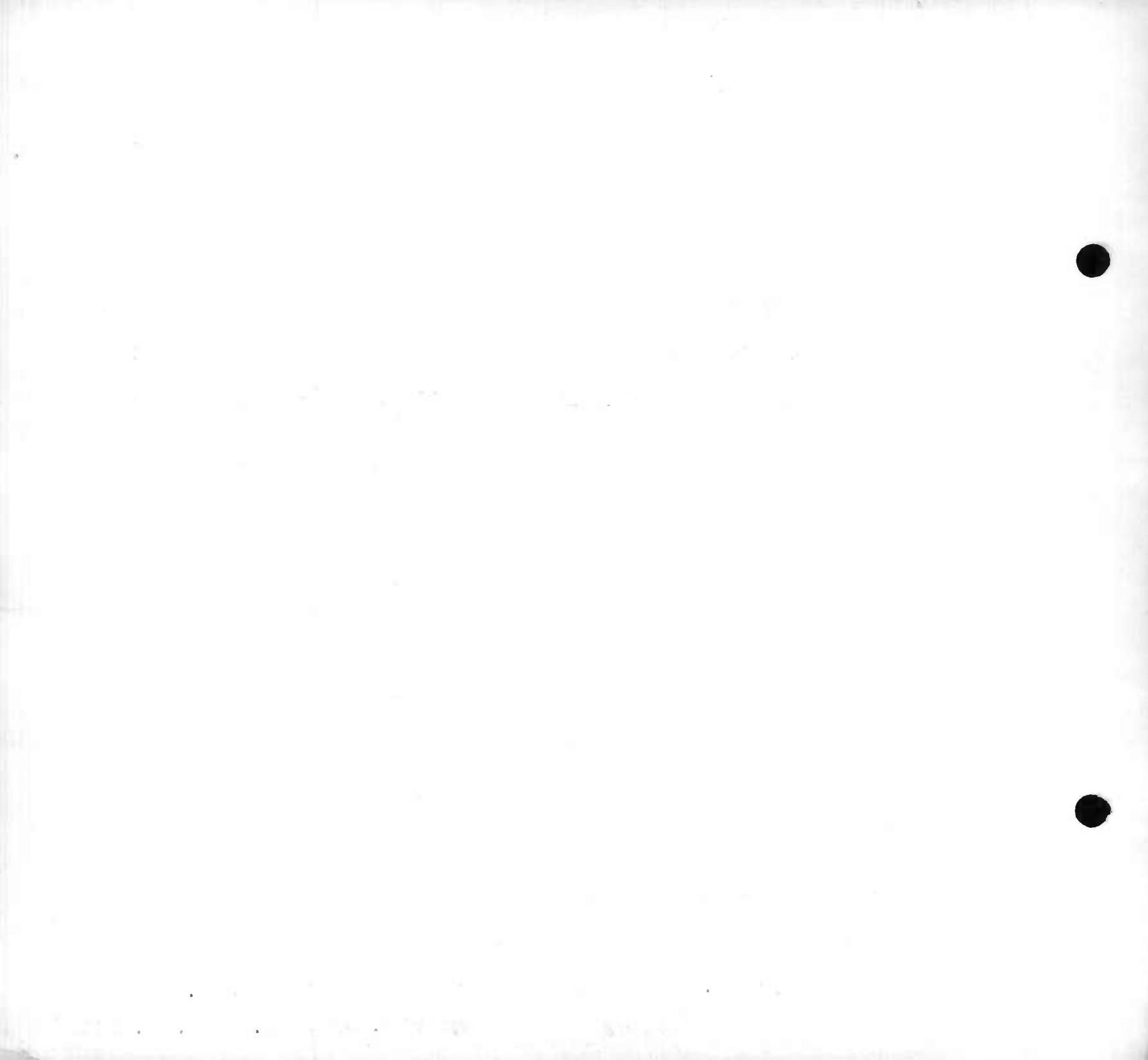
M-620		71 12071		BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH		REG. NO. 71 12071
BIRTH NO.		ARTHUR L MYERS Sr		2. DATE AND HOUR OF DEATH December 27, 1971 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 00				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2706 C. CITY OR TOWN Baltimore E. STREET AND NUMBER 2804 Beechland Ave.			
5. SEX Male RACE White 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				7. DATE OF BIRTH July 1, 1894 9. AGE (in years lost birthday) 77 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Self Employed				10B. KIND OF BUSINESS OR INDUSTRY Ice Co			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arthur J. Myers				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-32-2768 17. INFORMANT Mrs Ada V Myers ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  Carcinoma Prostate Nausea Arteriosclerotic Heart Disease Clogged Gall			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/25/71 to 12/27/71 that (I) (we) last saw the deceased alive on 12/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Donald R. Mintzer				23B. DATE SIGNED 12/27/71			
23C. PHYSICIAN'S NAME (Type) Dr. Donald R. Mintzer				23D. ADDRESS 3009 Evergreen Ave Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY or CREMATORIAL Moreland Mem Pk		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR DR. R. MINTZER		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md.		ADDRESS 21214	

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FEB 19 1988

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-450 71 12072		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12072	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/27/71 12 20 PM			
1. NAME OF DECEASED (Type or Print) <b>ADAM N. KLEIN</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY CITY 2641			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>		C. CITY OR TOWN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/6/93		9. AGE (in years last birthday) 78		If Under 1 Yr. Months: Days Hours If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Nicholas Klein		14. MOTHER'S MAIDEN NAME Magdaline ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>Yes WW I</b>		16. SOCIAL SECURITY NO. 218-07-1965		17. INFORMANT Miss Dorothy Klein	
				ADDRESS (Same)	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 27 1971</b> to <b>Dec 27 1971</b> that (I) (we) last saw the deceased alive on <b>Dec 27 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George C. Samuels MD</b>		23B. DATE SIGNED <b>12/27/71</b>			
23C. PHYSICIAN'S NAME (Last, First, Middle Initial)		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS <b>Md.</b>	
24A. BURIAL/CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert J. Sabo, Jr.</b>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
				ADDRESS <b>ADDRESS</b>	



7-540 71 12073

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12073

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Wilfore Feenell

2. DATE Known  Month Day Year Hour  
OF DEATH Estimated  12 24 71 M.  
M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*46*  
Lutheran Hospital3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 24 71 9:35 a.m.  
M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY 1503

6. SEX

male

7. RACE Negro

8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

C. CITY OR TOWN Balto.

D. INSIDE CITY LIMITS?  
YES  NO 

9. DATE OF BIRTH

10. AGE (In years  
last birthday) 30 If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1639 Thomas Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

MEDICAL CERTIFICATION	19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>E9651X</i> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
	(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C)					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>11</i>					

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
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22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) House	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>24 2415 North Avenue</i> 1503
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 24 71 ? (APPROX.) m.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Subject shot during altercation

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12/25/71
ACTUAL SIGNATURE <i>Peter Lipkovic, M.D.</i>		
EXAMINER'S NAME (Type)		

24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>12-29-71</i>	24C. NAME of CEMETERY or CREMATORIUM <i>MOUNT AUBURN CEM.</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>
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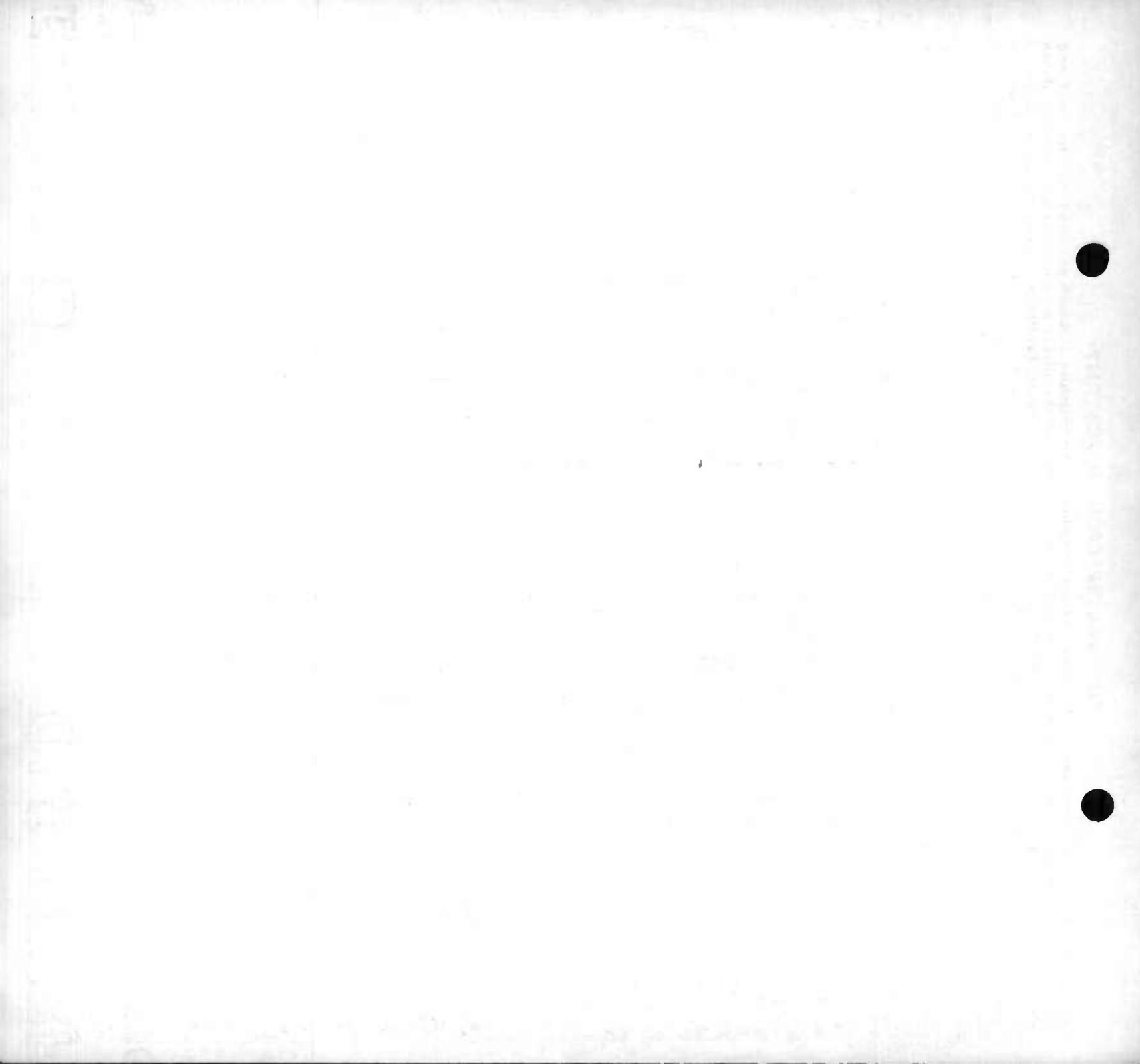
25A. DATE REC'D. BY HEALTH DEPT. <i>DEC 30 1971 Robert E. Nalley, Jr.</i>	25B. NAME OF REGISTRAR <i>Howard Co. Fun Home Columbia</i>	25C. FUNERAL DIRECTOR <i>Pike</i>	ADDRESS
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4 2848

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

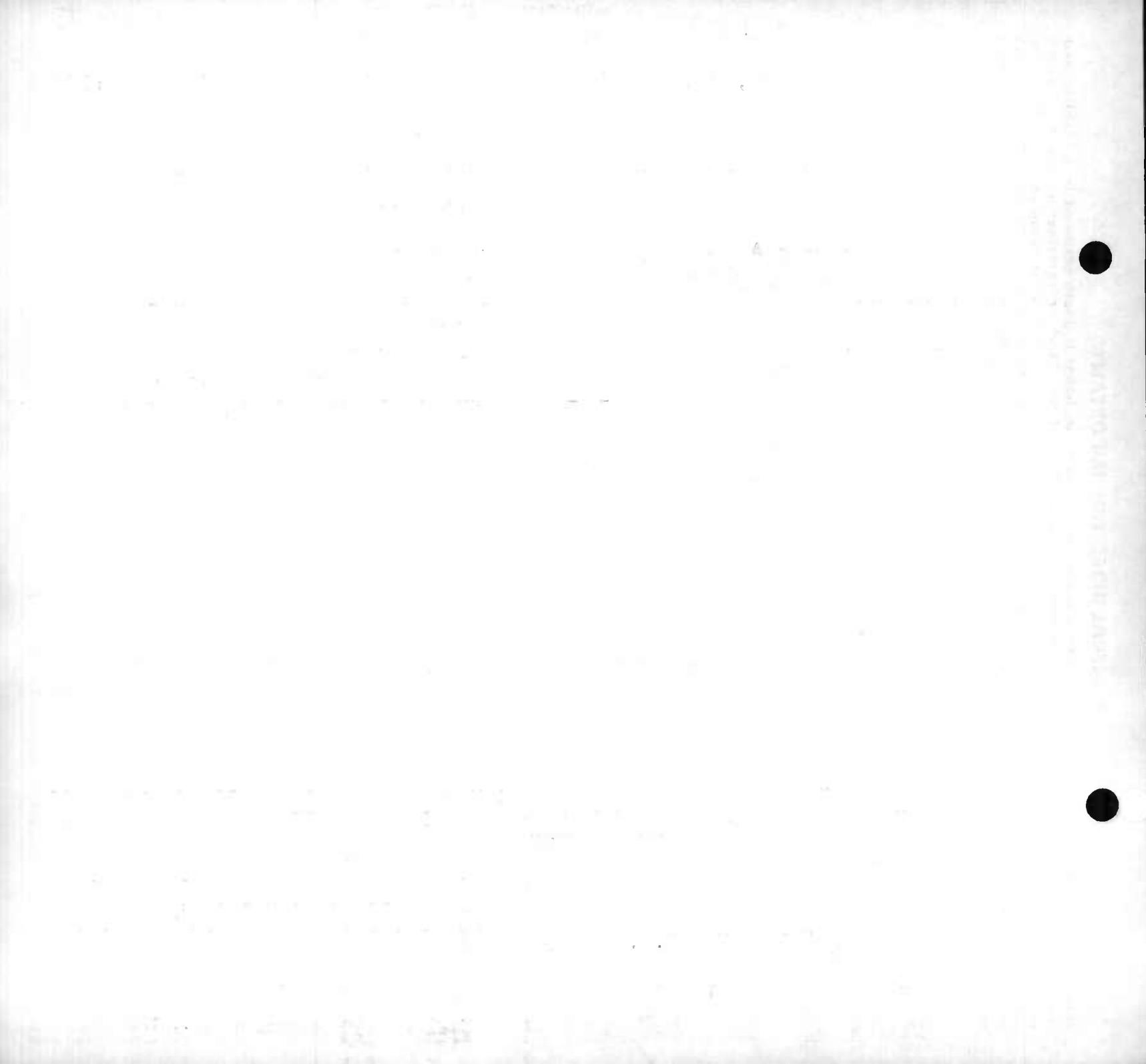
W-230 BIRTH NO.		71 12074		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 71 12074	
1. NAME OF DECEASED (Type or Print)		<b>DAVID A. WISCOTT</b>		2. DATE AND HOUR OF DEATH <b>12-28-71</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Church Home and Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore County 5300</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home and Hospital</i>		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>100 N Broadway St Balt. MD 21231</i>		C. CITY OR TOWN <b>Baltimore County</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-07-93</b>		9. AGE (in years last birthday) <b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Wiscott</b>						14. MOTHER'S MAIDEN NAME <b>Georgetti Doffer</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>A. Conrad Morris</b>		ADDRESS <i>Church Home Hosp</i>	
18. <b>185X1</b>		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Metastatic Cancer of prostate</i>			
		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
						(C) _____			
II MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>(In Baltimore City, give exact location)</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? <b>None</b>					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>12-15-1971</b> to <b>12-28-1971</b> that (I) (we) last saw the deceased alive on <b>12-28-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Gemma P. Indolos M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Dec. 28, 1971</i>			
23C. PHYSICIAN'S NAME (Type) <b>GEMMA P. INDOLOS M.D.</b>		23D. ADDRESS <i>Church Home &amp; Hospital</i>							
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>DEC 31, 1971</b>		24C. NAME OF CEMETERY or CREMATORIUM <b>ST. JAMES</b>		24D. LOCATION <i>NEW WINDSOR, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <b>HOWARD COUNTY</b> ADDRESS <i>ANDridge Harry 47212-007</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-620		71 12075		BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12075	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		HIRSCH, HELENE MARIE		2. DATE AND HOUR OF DEATH		DECEMBER 27 1971 7:30P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 2854	
ST AGNES HOSPITAL 40				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02 23 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 80		If Under 1 Yo Months Days Hours If Under 24 Hrs Min.	
11. BIRTHPLACE (State or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME OTTO UHLICH				14. MOTHER'S MAIDEN NAME MARIE TURK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 215-09-9689D		17. INFORMANT BALTIMORE MD 21229		ADDRESS ST AGNES RECORDS WILKENS & CATON AVES	
18. 15-3.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Pneumonia & colitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Co of my moist colon Inflammation to liver & (B) DUE TO, OR AS A CONSEQUENCE OF: Colitis			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Colitis			
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 20		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 06 19 71 to DECEMBER 27 19 71 that (X) (we) last saw the deceased alive on DECEMBER 27 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE JOSE APTER M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12 28 71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ST AGNES HOSPITAL		WILKENS & CATON AVES BALTO MD 21229			
24A. BURIAL-CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME of CEMETERY or CREMATORIUM Loudon Park		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR E. J. Fischer, A.D.		25C. FUNERAL DIRECTOR Witzig, 1630 Edmondson Ave., 21228		ADDRESS	
VS 150-REV. 1/1/68							



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>D-125</b>		71 12076	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	71 12076	
BIRTH NO.				CERTIFICATE OF DEATH X			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DE VAUGHN, GEORGE, SR				DECEMBER 28, 1971   11:20A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE & COUNTY	MARYLAND BALTIMORE 5300		
40		ST. AGNES HOSPITAL		C. CITY OR TOWN CATONSVILLE	D. INSIDE CITY LIMITS?		
				BALTIMORE	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	31 EDMONDSON RIDGE RD 21228		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
MALE	CAUCASIAN			07/11/05	66		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
PRINTER		SALES BOOK CO		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				ELIZABETH MC HARDY DE VAUGHN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NONE		215-07-1197		ST. AGNES HOSPITAL RECORDS			
18. I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Carcinoma of prostate gland		8 years	
		ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 28 19 71 to DECEMBER 28 19 71 that (I) (we) last saw the deceased alive on DECEMBER 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
				Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>	12-28-71
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		BALTIMORE, MARYLAND 21229	
Daniel Huerta				ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORIAL		24D. LOCATION (City, town, or county)	
Burial		12/31/71		New Cathedral		(State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 30 1971		Violet E. Salter, A.D.O.		Witzke, 71630 Edmondson Avenue		21228	

July 20, 1951

MAP / MAP

14-25-51

S. L. H.

at 732 H Lincoln

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH		71 12077	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		12/26/71 10:40 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Simpson Gertrude</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Duke Land Nursing Home 1501 N. Duke Land</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
5. SEX <i>F</i>		6. RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4/25/81</i>		9. AGE (In years last birthday) <i>90</i>		11. Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>21766830</i>		17. INFORMANT <i>Joyce Russell, 206 Callican Ave</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				ADDRESS	
This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>CH. BRAIN SYNDROME</i> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C).....			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/8/1921</i> to <i>12/26/1971</i> that (I) (we) last saw the deceased alive on <i>12/26/1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Philip E. B. Rydell Jr.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/26/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>PHILLIP E. B. RYDELL JR.</i>		23D. ADDRESS <i>2707 HANSON AVE, BALTIMORE MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-22</i>		24C. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>				(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1971</i>		25B. NAME OF REGISTRAR <i>Philip E. B. Rydell Jr.</i>		25C. FUNERAL DIRECTOR <i>Philip E. B. Rydell Jr.</i>	
				ADDRESS	
VS 150-REV. 1/1/68					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

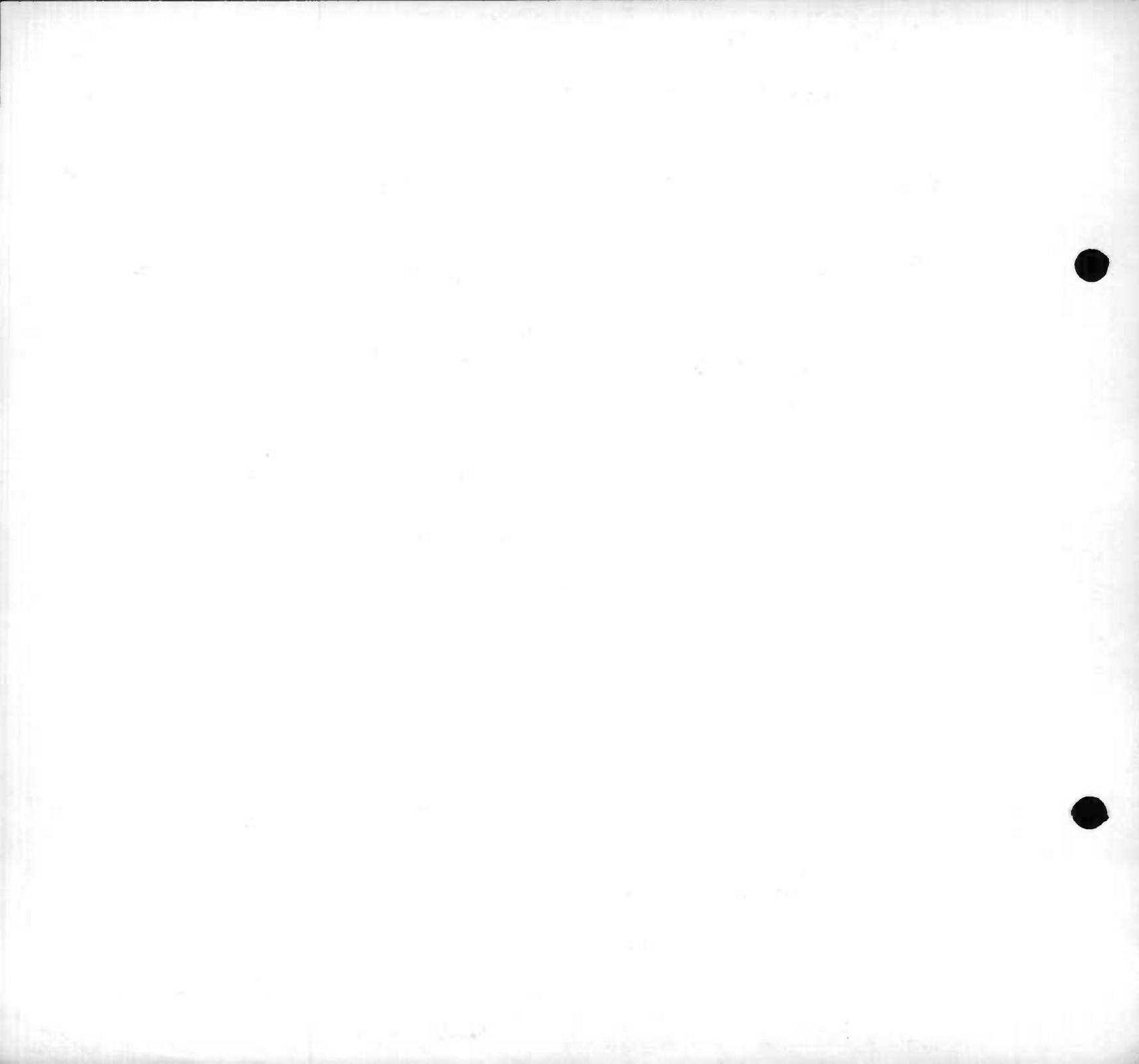
C-350 71 12078		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12078	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH 12-27-71 9 18 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1002	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore	
33 The Johns Hopkins Hospital				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				715 N. Central Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	If Under 1 Yr. Months Days Hours Min.
Female	Negro	6/26/05	66		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				Virginia USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Unknown				Mary Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Helen J. Cheatham, Son	
18. CAUSE OF DEATH				ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ospheno, etc. It means the disease, injury or complication which caused death.)				~ 10 days	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
HASCVD, DIABETES					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
N/A				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
N/A		N/A		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
N/A		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		N/A	
22. I certify that (I) (the physician) attended the deceased from _____				12-24 19 71 to 12-27 19 71	
that (I) (we) last saw the deceased alive on _____				and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED	
Steven E Rubin MD		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		12-27-71	
23C. PHYSICIAN'S NAME (Type)		DEGREE		23D. ADDRESS	
STEVEN E RUBIN MD				JOHNS HOPKINS HOSP	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIAL	
Burial 12-31-71		McGaway Crt		24D. LOCATION (City, town, or county) (State)	
				Al County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 30 1971 Robert E. Gandy Jr.				ADDRESS	
				Johns Hopkins Hospital	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

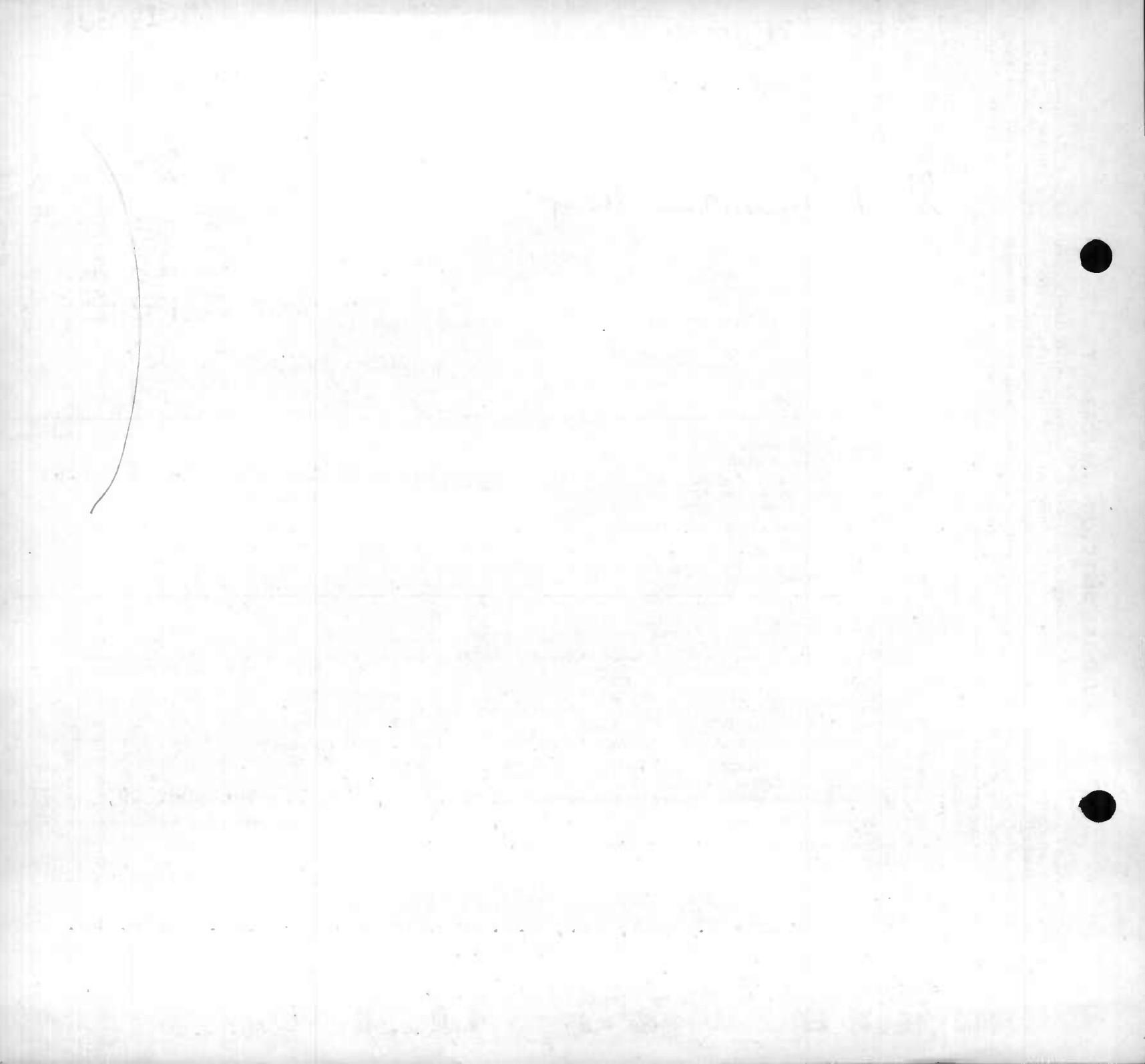
B-620 BIRTH NO. 11-218391 12079		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X		REG. NO. 71 12079			
1. NAME OF DECEASED (Type or Print) <b>BROOKS, BABY GIRL</b>		2. DATE AND HOUR OF DEATH <b>12/28/71</b>		9:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>CHURCH HOME AND HOSPITAL</b> <b>35</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  <b>Maryland</b> <b>Pasadena</b>		A. STATE & COUNTY <b>5200</b>			
F N		5. SEX 6. RACE  WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  8. DATE OF BIRTH <b>12/27/71</b>	9. AGE (in years last birthday) <b>2</b>		If Under 1 Yr. Months 2 Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Betty Johnson</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William R Brooks Son</b>		ADDRESS		18. CAUSE OF DEATH <b>778.81</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osthenoic, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Immaturity (25 weeks)</b> DUE TO, OR AS A CONSEQUENCE OF:		(B) CONDUCING CAUSES <b>Cardiorespiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF:		(C) MARKED ASPIRES	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slothing the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <b>12/27/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27/71</b> to <b>12/28/71</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>J. Eufemio</b>		23B. DATE SIGNED <b>12/28/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHNNY EUFEMIO M.D.</b>		23D. ADDRESS <b>Church Home + Hospital</b>		24A. BURIAL CREMATION, DATE REMOVAL (Specify) <b>Burial 12-29-71</b>		24B. DATE <b>12-29-71</b>	
24C. NAME OF CEMETERY OR CREMATORIAL <b>Mt Calvary Cemt</b>		24D. LOCATION (City, town, or county) <b>All County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>		25B. NAME OF REGISTRAR <b>Elroy Wilson</b>	
25C. FUNERAL DIRECTOR <b>Elroy Wilson</b>		ADDRESS <b>1000 Brandywine</b>		25D. DATE REC'D BY FUNERAL DIRECTOR <b>DEC 30 1971</b>			
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

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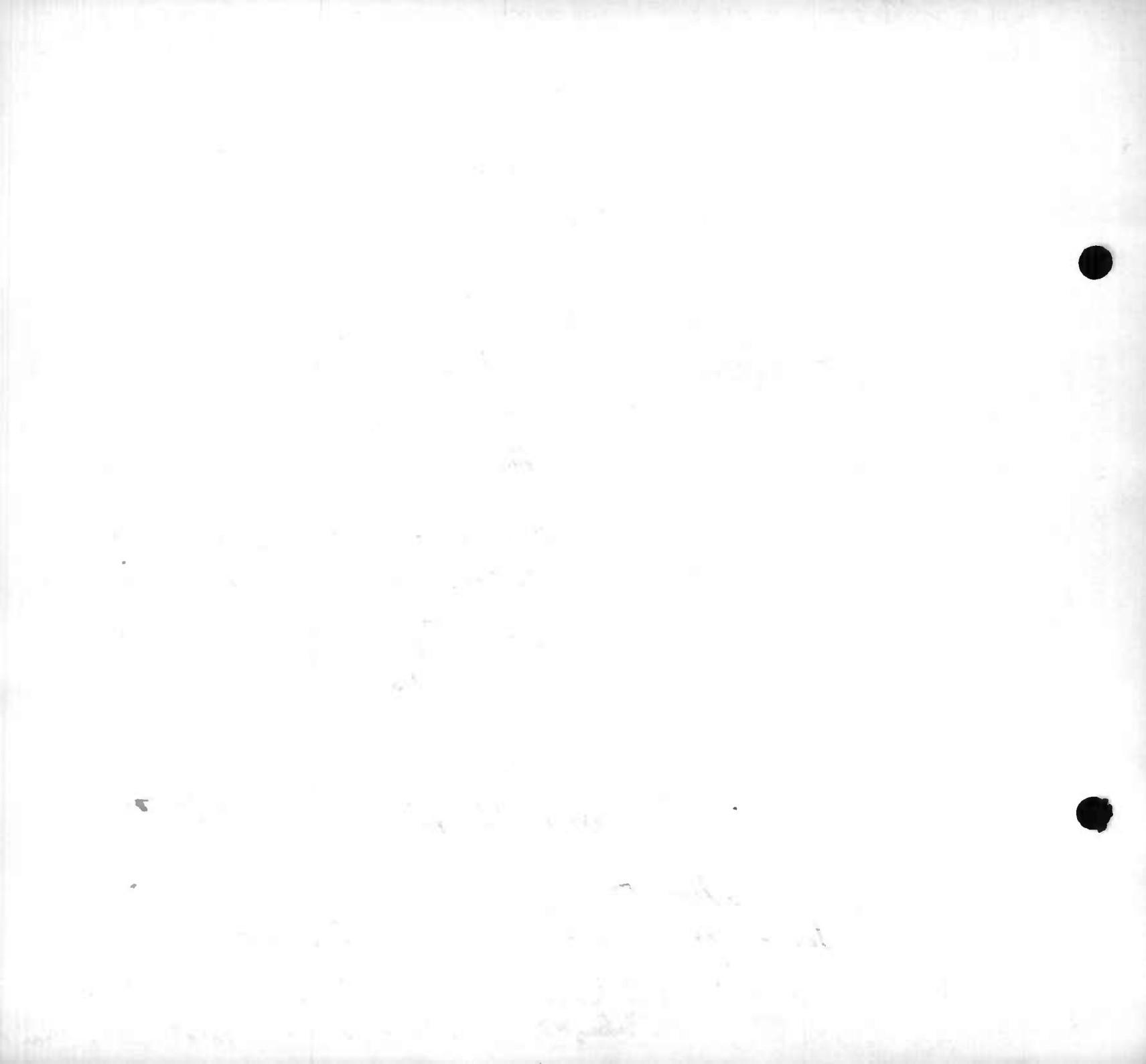
B-400		71 12080		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12080	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Annie E. Blue		2. DATE AND HOUR OF DEATH December 29, 1971   6:15 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY 1402			
Good Samaritan Hosp				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FEMALE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23 1924		9. AGE (in years last birthday) 45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				South Carolina		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Elijah McDonald		Emma Gregg					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Carol P Blue		Same	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE Metastatic Colonic Carcinoma		4 months	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
MEDICAL CERTIFICATION		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
		none		XXX		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
no		XXX		XXX			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
XXX		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		XXX			
22. I certify that (I) (this hospital) attended the deceased from December 28, 1971 to December 29, 1971, that (I) (we) last saw the deceased alive on December 28, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE		George H. Sack, Jr.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/29/71	
23C. PHYSICIAN'S NAME (Type)		George H. Sack, Jr., M.D.		23D. ADDRESS 5600 Loch Raven Blvd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-4-72		24C. NAME OF CEMETERY or CREMATORIAL Mt Auburn Cemt		24D. LOCATION (City, town, or county) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR John O. Wilson		25C. FUNERAL DIRECTOR John O. Wilson		ADDRESS 1000 Brantley St	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>71 12081</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>481 12081</u>	
1. NAME OF DECEASED (Type or Print) <u>HATCHETT William</u>		2. DATE AND HOUR OF DEATH <u>12/28/71</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>90 HARBOR View Nursing Center</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Wilmington Del.</u> D. INSIDE CITY LIMITS? E. STREET AND NUMBER <u>505 Greenbank Av. V07</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/25/98</u>	9. AGE (in years lost birthday) <u>73</u>	If Under 1 Yr. Months
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Henry Hatchett</u>		14. MOTHER'S MAIDEN NAME <u>Irene Jackson - Virginia</u>		12. CITIZEN OF WHAT COUNTRY? ADDRESS	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>813 09 9528A</u>		17. INFORMANT	
18. <u>412-9</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month Day Year) (Hour (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/24/69</u> 19 <u>to</u> <u>12/28/71</u> 19 that (I) (we) last saw the deceased alive on <u>12/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sergeant Blum</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jos. S. BLUM, MD</u>		23D. ADDRESS <u>1115 N. CALVERT ST</u>		DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-30-71</u>		24C. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Calvary Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1971</u>		25B. NAME OF REGISTRAR <u>Rober E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Ed P. Blum</u> ADDRESS <u>1000 Brantley Ave.</u>	



71 12082

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12082

**BIRTH NO**

REG. NO.

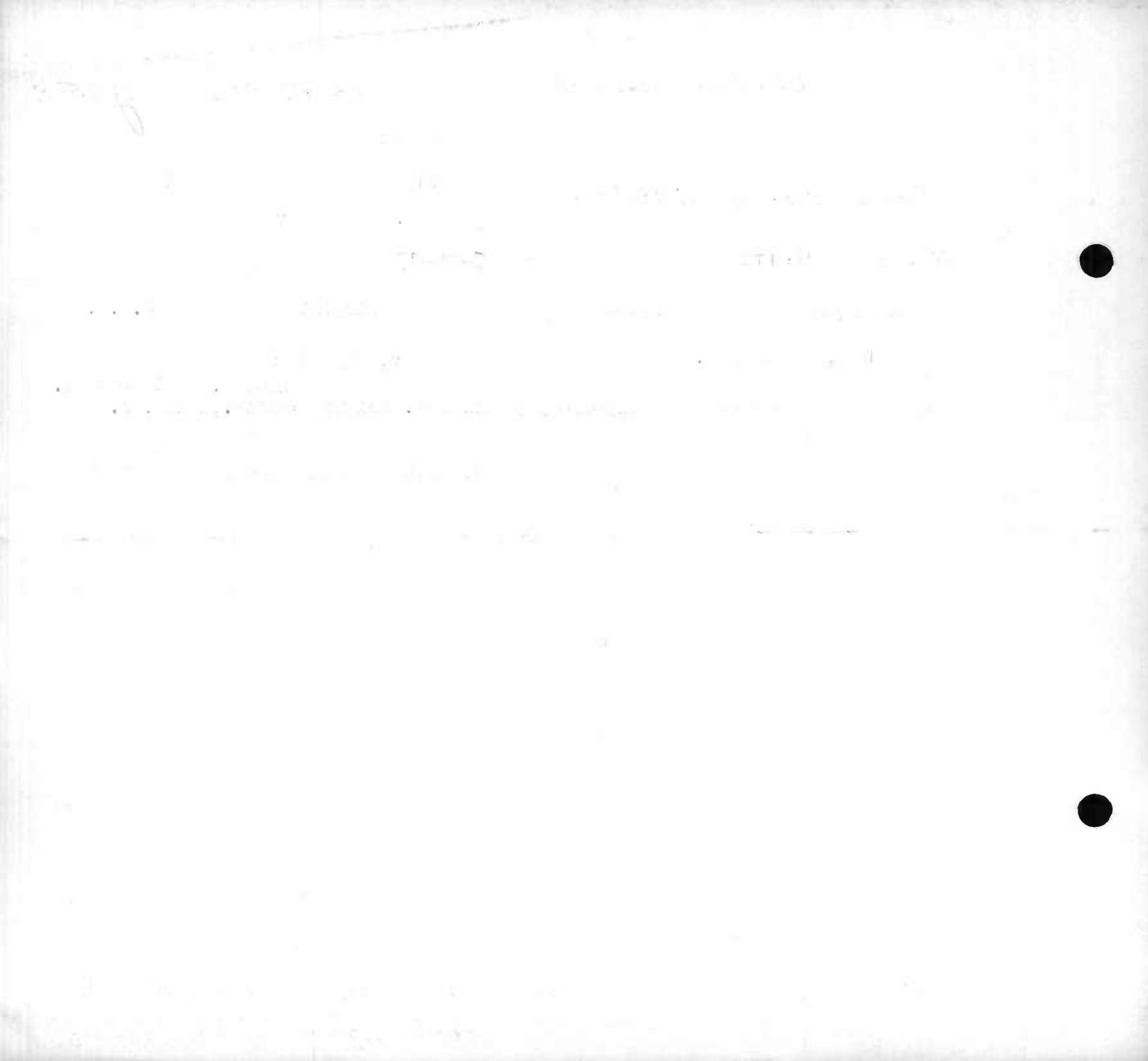
NAME OF DECEASED (Type or Print)		(MICHAEL J. SCHULTZ - SZULC.)		DATE OF DEATH	Known <input type="checkbox"/> Month Estimated <input type="checkbox"/>	Day	Year	Hour	
PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MICHAEL SCHULTZ - SZULC.		DATE PRONOUNCED DEAD	Month	Day	Year	Hour	
<b>CERTIFICATE AMENDED</b> BALTIMORE CITY HOSPITAL		2-16-72		December 28, 1971		3:40 P.M.			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH July 6, 1922		10. AGE (in years last birthday) 49	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2609		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U.S.A.	14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die-Setter		14B. KIND OF BUSINESS OR INDUSTRY Anchor Post Co.		15. MOTHER'S MAIDEN NAME Mary A. Winiecki		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 216-12-7456	18. INFORMANT Frank T. Schultz		3504 O'Donnell Street Balto., 21224, Md.				
19. 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Acute hemorrhagic pancreatitis Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)							
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes						
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/29/71									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-31-71.	24C. NAME of CEMETERY or CREMATORIUM St. Stanislaus Cemetery	24D. LOCATION (City, town, or county) (State) 6015 Boston Ave., Balto., Md.						
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971	25B. NAME OF REGISTRAR Robert E. Jacoby, M.D.	25C. FUNERAL DIRECTOR Charles S. Zeiler	ADDRESS 901 S. Conkling St. Balto., 21224, Md.						

2-16-1972 - Letter from - Office of the Chief Medical Examiner  
Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

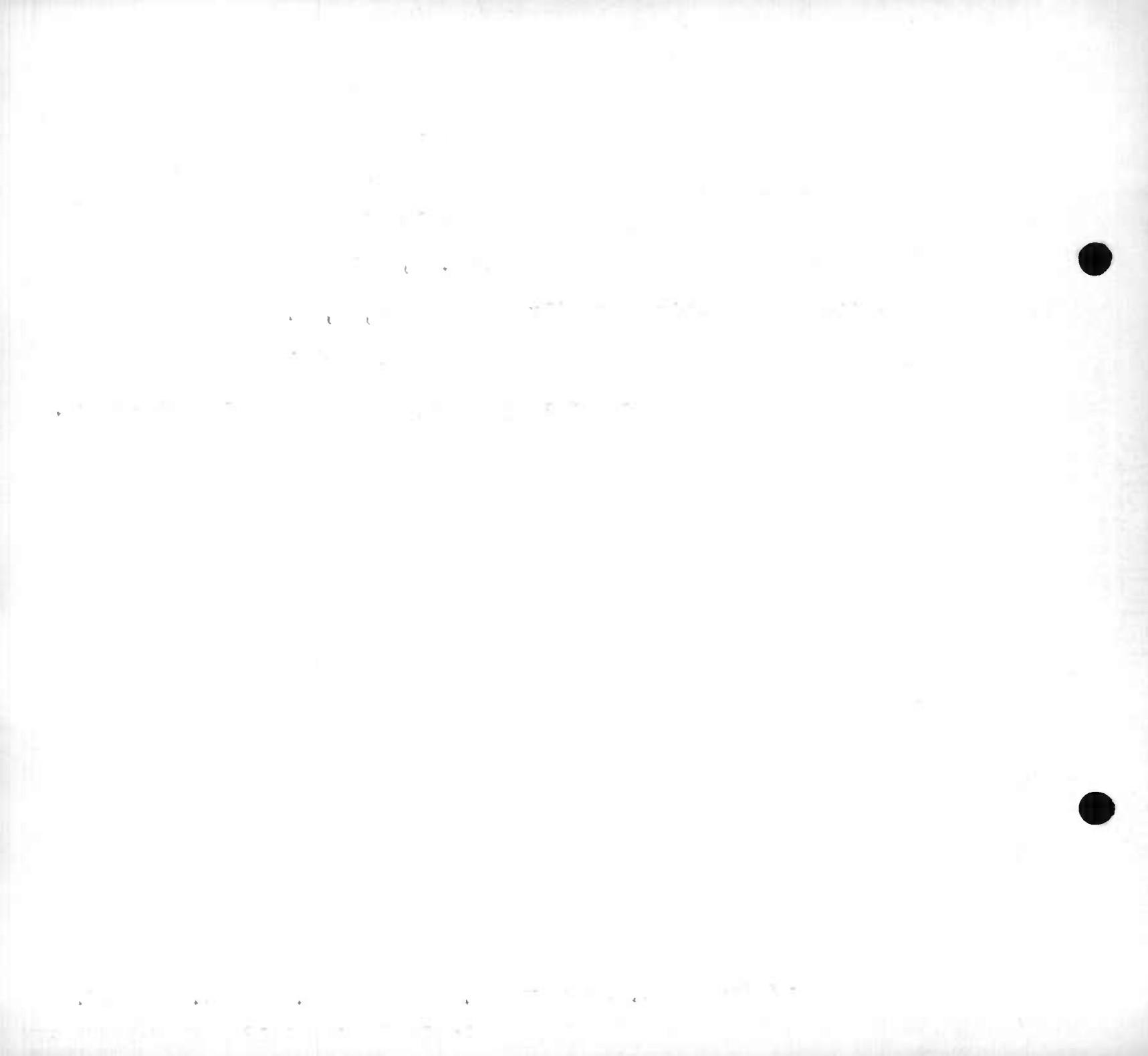
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			
BIRTH NO. <b>71 12083</b>	REG. NO. <b>71 12083</b>		
1. NAME OF DECEASED (Type or Print) <b>William T. GALLIER</b>		2. DATE AND HOUR OF DEATH <b>12-27-71 5:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>203</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>	(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>728 S. BROADWAY</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-14-33</b>
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Unemployed</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	9. AGE (in years lost birthday) <b>58 57</b>	If Under 1 Yr. Months Days Hours Min. <b>57</b>
13. FATHER'S NAME <b>GALLIER, THOMAS W.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Probable Heart Attack</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>GI bleeding</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  <b>Chronic Alcoholism + Post-Hepatitis</b> 10 yrs	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>0</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>12-27-1971</b> to <b>12-27-1971</b> that (1) (we) last saw the deceased alive on <b>12-27-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE  <i>Neil R Miller, MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>12-27-71</b>
23C. PHYSICIAN'S NAME (Type) <b>NEIL R MILLER, MD</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-29-71</b>	24C. NAME of CEMETERY or CREMATORIUM <b>OAK LAWN CEM.</b>	24D. LOCATION (City, town, or county) <b>7225 EASTERN BLVD. BALCO., MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Barber, MD</b>	25C. FUNERAL DIRECTOR <b>Charles S. Geiler</b>	ADDRESS <b>6234 EASTERN AVE BALTO., 21224, MD.</b>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12084		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12084	
1. NAME OF DECEASED (Type or Print)		REGISTER, IOLA		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 12-28-71 3:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2717			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		4916 PALMER AVENUE					
5. SEX F	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 8, 1922	9. AGE (in years lost birthday) 49	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) FORRESTON, S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JBE CARTER		14. MOTHER'S MAIDEN NAME CARRIE CANTY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 22 1203		17. INFORMANT Herbert Regester		ADDRESS 4916 Palmer Ave.	
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE Subarachnoid hemorrhage 4 d DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertension DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 25 1971 to Dec 28 1971 that (I) (we) last saw the deceased alive on Dec 28 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Srinu Boonsue				23B. DATE SIGNED 12-28-71			
23C. PHYSICIAN'S NAME (Type) SRI SOOK BOONSUE				Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>	23D. ADDRESS Sinai Hospital, Belfo, MD 21215
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/72		24C. NAME of CEMETERY or CREMATORIAL MT. CALvary CEM.		24D. LOCATION (City, town, or county) BALTO. (AA Co.)	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR John E. Wilson		25C. FUNERAL DIRECTOR Lewis T. Gwynn		ADDRESS 4517 PARK HEIGHTS AVE	
VS 150-REV. 1/1/68							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the physician by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-400		71 12085		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12085	
BIRTH NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		Loula Elmer Sewell		2. DATE AND HOUR OF DEATH 12/29/1971 1 A.M.		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE Maryland B. COUNTY 2748					
FULL NAME OF HOSPITAL OR INSTITUTION  90 Edgewood Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/1877		9. AGE (in years lost birthday) 94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Elmer		14. MOTHER'S MAIDEN NAME Henrietta Langrall					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-3791		17. INFORMANT J-1 Mrs. Clinton C. Davison		ADDRESS 3922 Cloverhill Road 21218	
18. #21X! DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
CAUSE OF DEATH  (A) IMMEDIATE CAUSE (1) Bronchitis - Pneumonia 3 days DUE TO, OR AS A CONSEQUENCE OF:  (B) (2) Viral Syndrome 4 days DUE TO, OR AS A CONSEQUENCE OF:  (C) Arterio Sclerotic Heart Disease 10 yrs - cerebral vascular sclerosis -							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from April 9-1967 to Dec. 29 1971 that (1) (we) last saw the deceased alive on Dec 29 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.							
23A. SIGNATURE Earl L. Chambers MD		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 12/29/71	
23C. PHYSICIAN'S NAME (Type) Dr. Earl Chambers		23D. ADDRESS 100 W. Coldspring Lane					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIUM Loudon Park		24D. LOCATION Baltimore	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Jenkins & Sons Co.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-230 71 12086

### BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

71 12086

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CLARENCE EAST

2. DATE AND HOUR OF DEATH

12/24/71

11

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

JOHNS HOPKINS

33

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE & COUNTY  
MARYLAND

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER  
533 N. FULTON AVE.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

04/10/12

9. AGE (in years  
last birthday)

59

10. Under 1 Yr.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MUSICIAN

10B. KIND OF BUSINESS OR INDUSTRY

MUSIC

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LAWSON, MARY Edward East

14. MOTHER'S MAIDEN NAME

EAST. WILLIAM Mary Turner

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213 05 2860

17. INFORMANT

Mrs Elizabeth East 533 N. Fulton Ave

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE POSSIBLE ASPIRATION  
DUE TO, OR AS A CONSEQUENCE OF:

(B) BRAIN STEM INFARCT  
DUE TO, OR AS A CONSEQUENCE OF:

(C) MALIGNANT HYPERTENSION

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

CNS LUES

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work

Not While  
At Work

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_

12/14

1971

to 12/24

1971

that (I) (we) last saw the deceased alive on \_\_\_\_\_

12/24 1971

and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. FEINGLASS, MD.

DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

12/24/71

23C. PHYSICIAN'S  
NAME (Type)

E. FEINGLASS MD.

DEGREE

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

12-30-71

24C. NAME OF CEMETERY OR CREMATORIUM

W.H. Calvary Ch. Cem

24D. LOCATION

Aberdeen

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

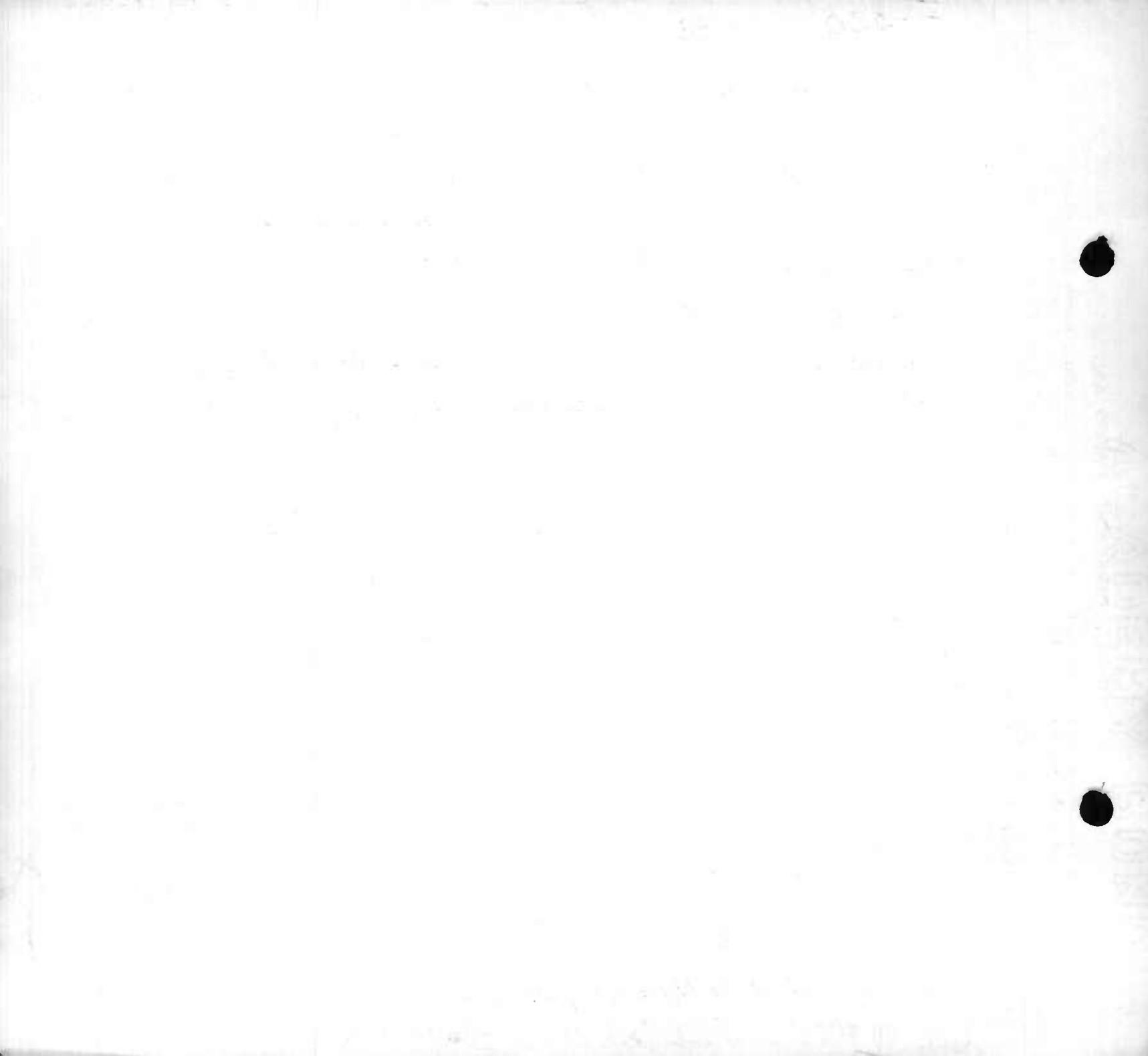
R.C. Johnson

25C. FUNERAL DIRECTOR

Joseph A. Russ

ADDRESS

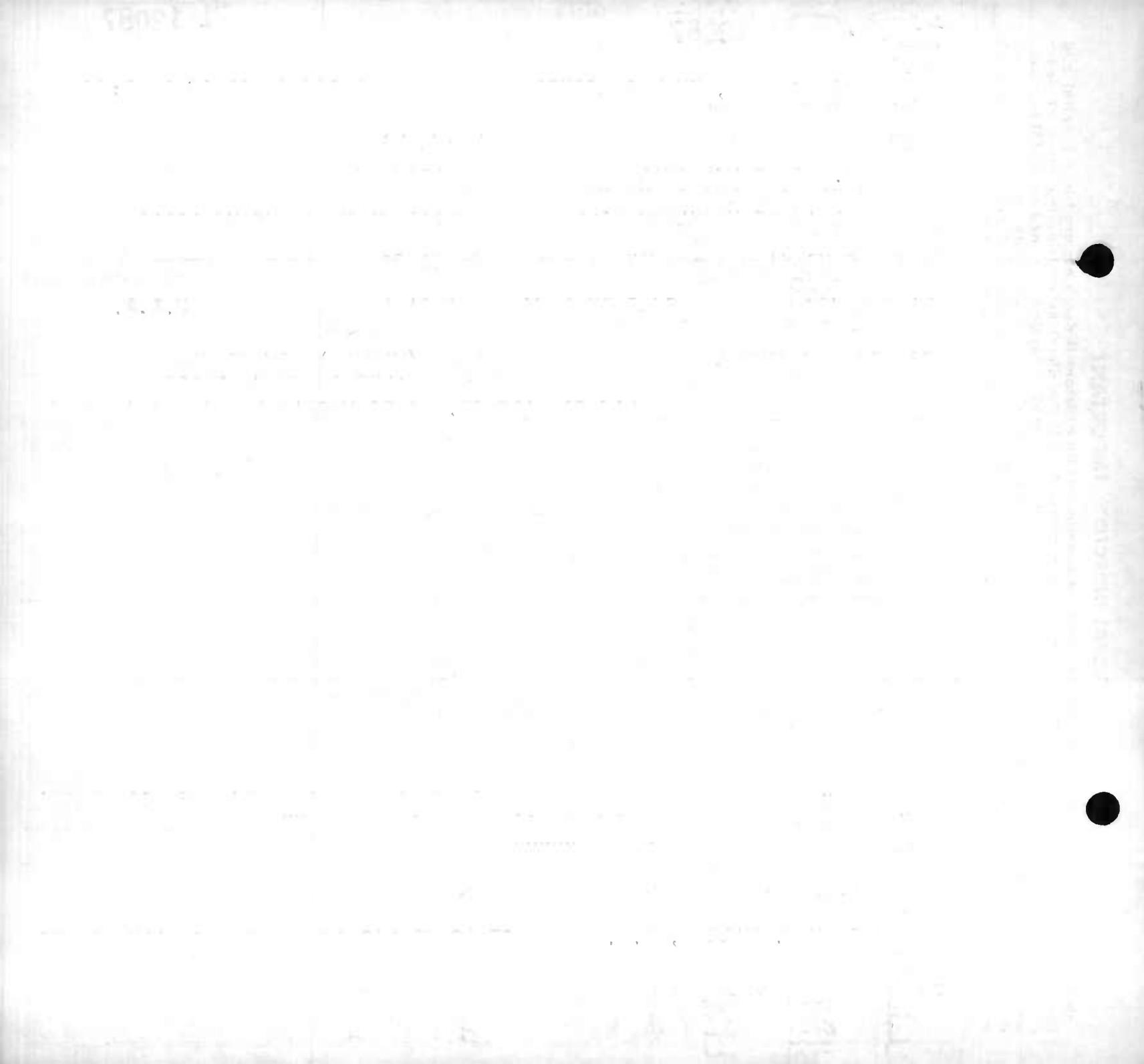
2222 w. North Av.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-324 71 12087		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12087	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HOWDY SHELL, THOMAS LESTER		DECEMBER 31 1971 7:55A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005			
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 06 03 03		9. AGE (in years less birthday) 68		If Under 1 Yr. Months: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME GEORGE HOWDYSHELL		14. MOTHER'S MAIDEN NAME ANNA (HARMON) HOWDYSHELL			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 230 01 9320		17. INFORMANT WILKENS AVENUE 21229 ADDRESS ST. AGNES HOSPITAL RECORDS CATON &	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Chronic Obstructive Pulmonary Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Bronchitis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 29 1971 to DECEMBER 31 1971 that (X) (we) last saw the deceased alive on DECEMBER 31 1971 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) X(X)d(X)(X) view the body after death.					
23A. SIGNATURE Joseph H. Miller, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/31/71	
23C. PHYSICIAN'S NAME (Type) JOSEPH H. MILLER, M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY or CREMATORI Mt. Olivet	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State) (2001)		25C. FUNERAL DIRECTOR Schowatz, Inc. Frederick Ave	
25A. DATE RECEIVED BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Gandy		25D. ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
		CERTIFICATE OF DEATH		71 12088	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Frederick W. PFISTER		12-31-1971		2 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULTON MEMORIAL HOSPITAL 1-7-72		A. STATE MARYLAND		B. COUNTY 27+8	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN Balt.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
CERTIFICATE AMENDED		E. STREET AND NUMBER 5651 Pindell Ave Balt. 21239			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-31-94	9. AGE (in years lost birthday) 77	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		10B. KIND OF BUSINESS OR INDUSTRY CUTAW SAVINGS BANK MID-NATL. BANK		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME ADOLPH PFISTER		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 391-20-0470		17. INFORMANT ETHEL (WIFE) ADDRESS	
18. CAUSE OF DEATH 410.91  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec 11 hours.	
II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-30 1971 to 12-31 1971 that (I) (we) last saw the deceased alive on 12-31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-31-71	
23C. PHYSICIAN'S NAME (Type) TULLIO BERTORINI		23D. ADDRESS DEGREE		UNION MEMORIAL HOSPITAL	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-72		24C. NAME of CEMETERY or CREMATORIUM Gardens of Faith	
24D. LOCATION Balt., Md.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR DEGREE		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS	
				4905 York Road Balt., Md. 21212	

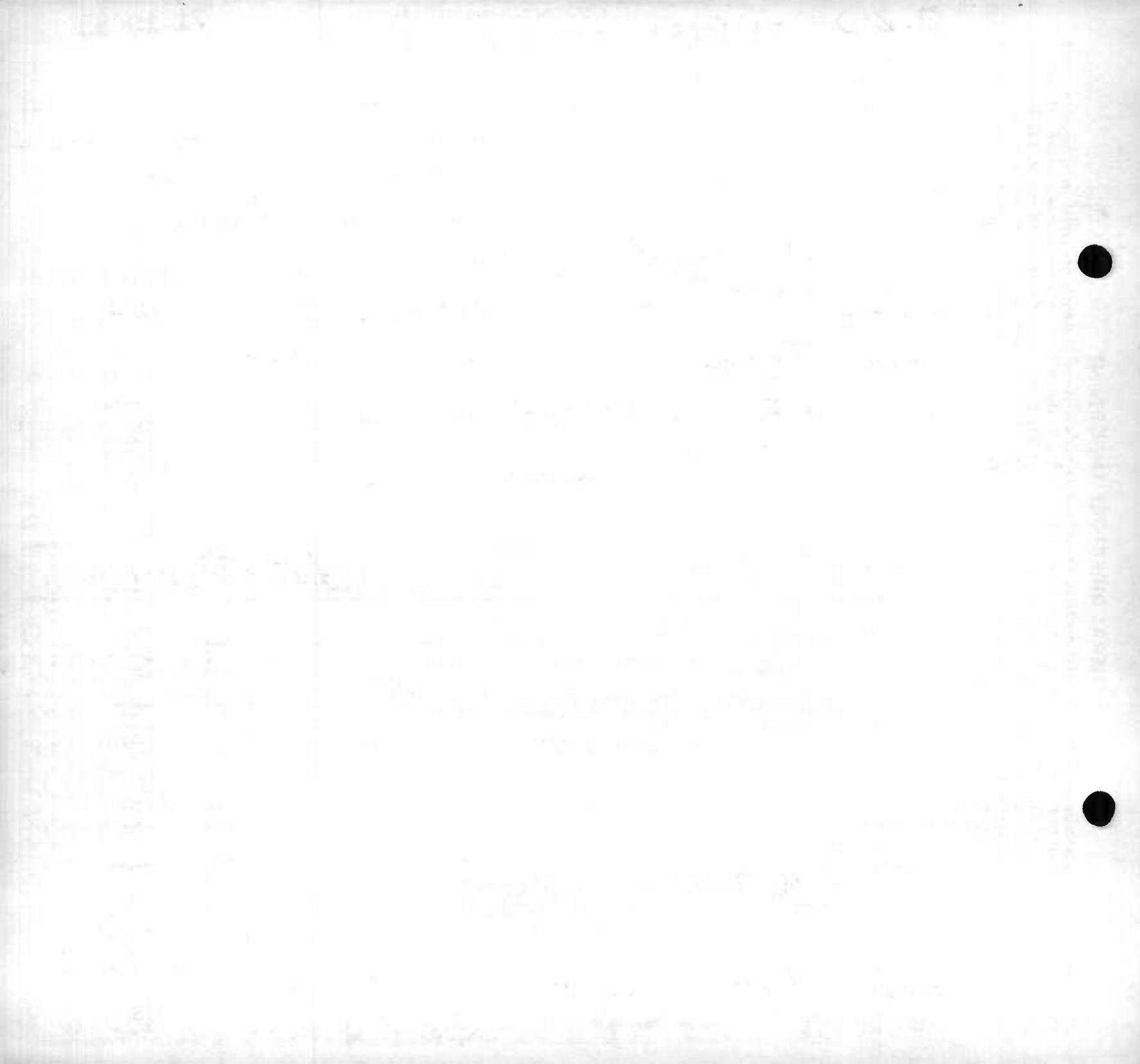
1-7-72 - Correction form from Funeral Director

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any kind; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

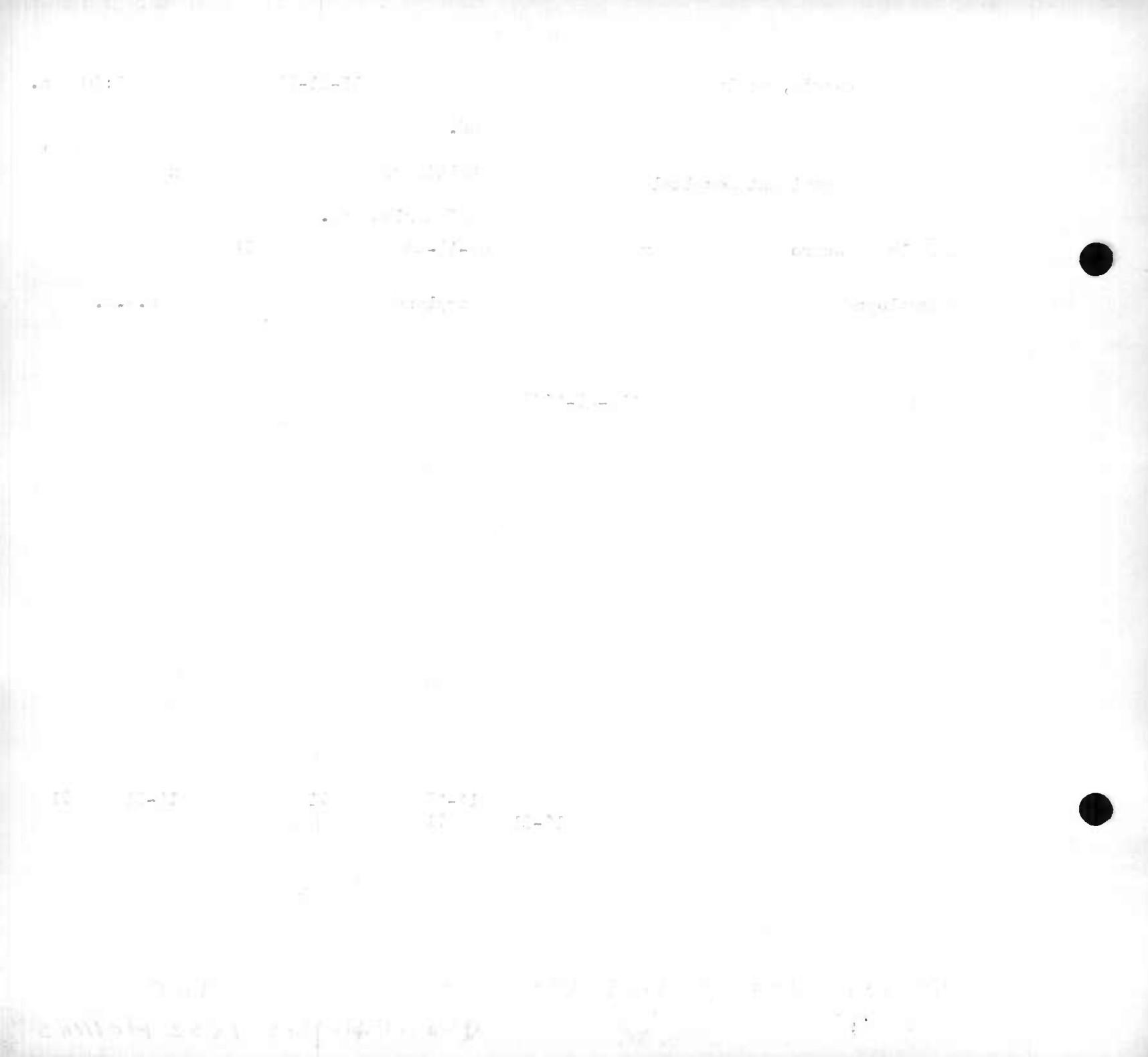
G-400 BIRTH NO. 71 12089		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12089	
1. NAME OF DECEASED (Type or Print) HARRY GILL		2. DATE AND HOUR OF DEATH 12-31-71		2.45 pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  South Baltimore General Hospital 43		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE B. COUNTY  2416 Marborn Avenue, Maryland		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE B. COUNTY  C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER  2416 Marborn Avenue 2572	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-08	9. AGE (in years last birthday) 63	10. KIND OF BUSINESS OR INDUSTRY chauffer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. BIRTHPLACE (State or foreign country) Baltimore, Md.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Thomas		14. MOTHER'S MAIDEN NAME Laura Crowther		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service Yes WW II	
16. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT R. Sirithara. South Baltimore General Hosp.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		(B) Encephalopathy DUE TO, OR AS A CONSEQUENCE OF:		(C) Hepatic failure due to portal cirrhosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/11	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED nil	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) nil		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nil		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) nil	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.) nil		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? nil	
22. I certify that (I) (this hospital) attended the deceased from 12-22-1971 to 12-31-1971 that (I) (we) last saw the deceased alive on 12-31-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Sirithara		M.D. DEGREE	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) R. SIRITHARA H.D. DEGREE		23D. ADDRESS South Baltimore General Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/72	24C. NAME OF CEMETERY OR CREMATORIUM Crider Cemetery		24D. LOCATION (City, town, or county) St. Benjamin's Lutheran Church, Carroll Co., Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1971		25B. NAME OF REGISTRAR Robert E. Gabay, Jr. A.D.		25C. FUNERAL DIRECTOR Howard Schwartz, Inc. ADDRESS 1101 Frederick Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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H-620 71 12090		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12090	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-31-71		1:40 a.m.	
1. NAME OF DECEASED (Type or Print) <b>Harris, Mamie</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  39 Provident Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md. B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION  39		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 903 Harlem Ave.					
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-15-00	9. AGE (in years lost birthday) 71	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO 215-07-2650		17. INFORMANT ADDRESS	
<b>18. CAUSE OF DEATH</b>					
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> <p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. MEDICAL CERTIFICATION		19B. DATE OF OPERATION		19C. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-27 19 71 to 12-31 19 71 that (I) (we) last saw the deceased alive on 12-31 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. G. Mercado</i>		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/31/71	
23C. PHYSICIAN'S NAME (Type) <b>M. G. Mercado</b>		23D. ADDRESS Provident Hospital Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE 1-4-71		24C. NAME OF CEMETERY OR CREMATORIUM Mt Auburn	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972 Robert E. Farley M.D.		25B. NAME OF REGISTRAR D. D. J.		25C. FUNERAL DIRECTOR Wesley Hughes 1532 Hollens St	
VS 150-REV. 1/1/68					



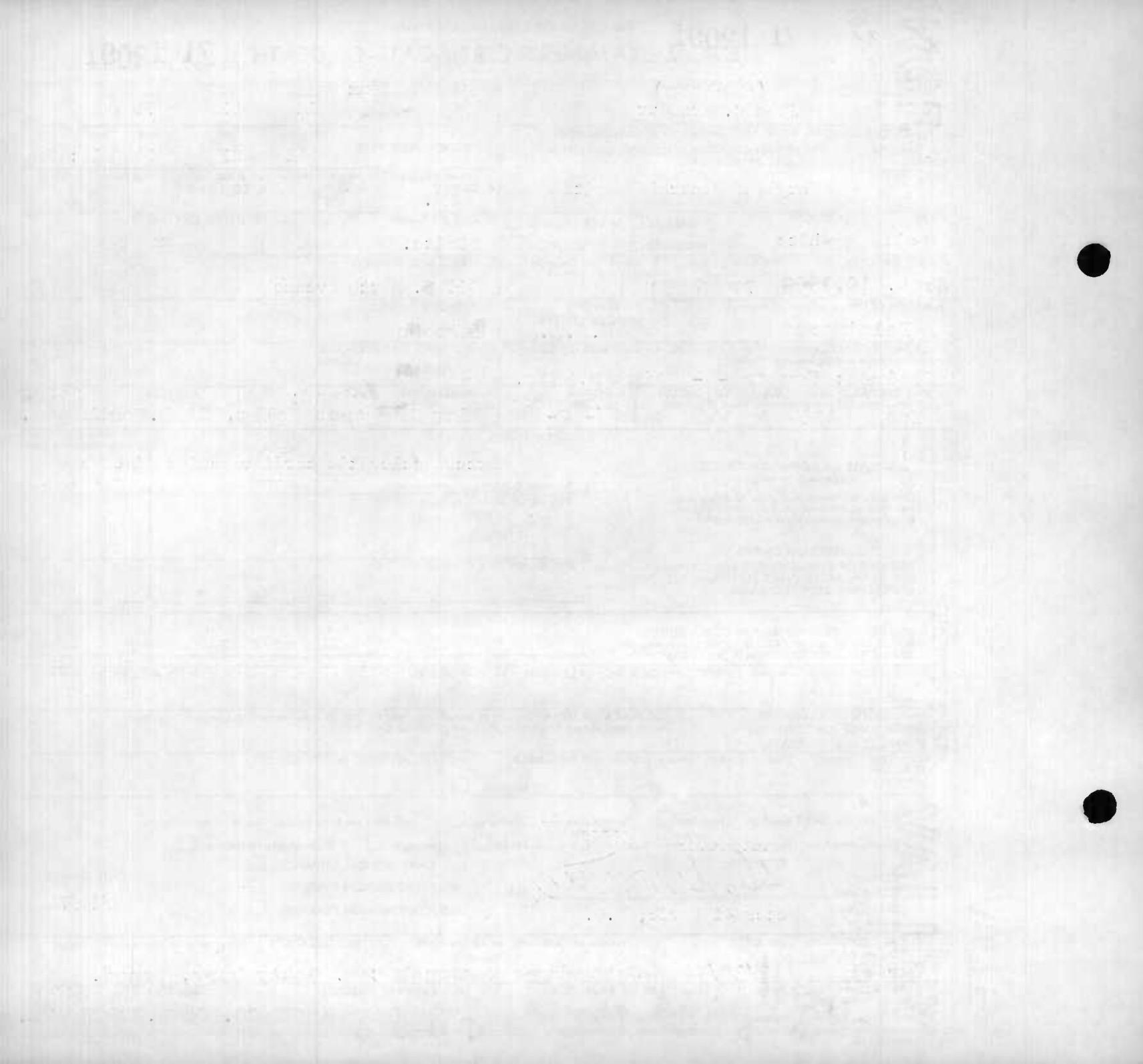
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12091

BIRTH NO.

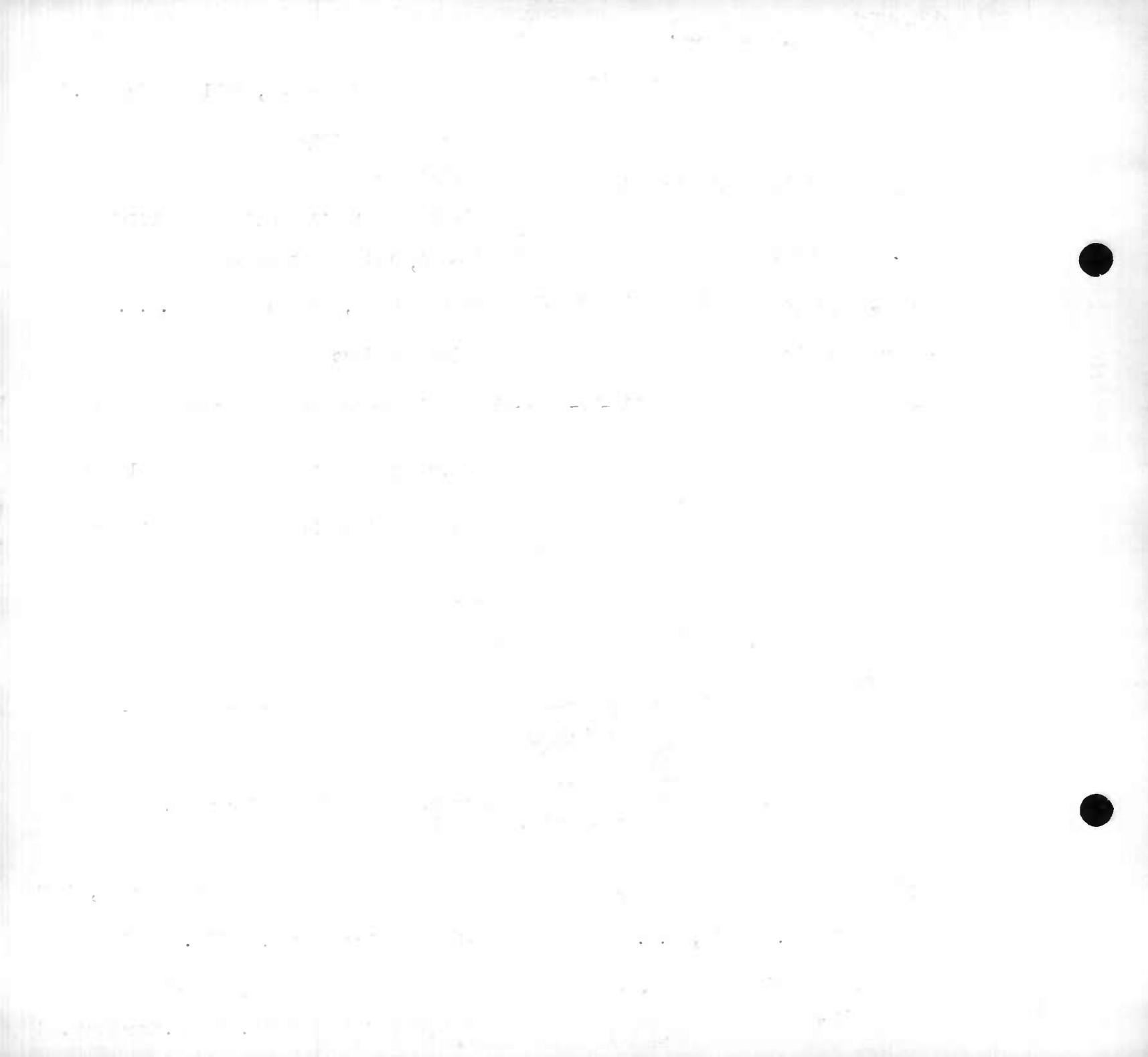
1. NAME OF DECEASED (Type or Print)		(Carlton) John C. Krauder		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	Month 12	Day 23	Year 71	Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>48</i>		(If not in hospital or institution, give street address or location) Maryland General Hospital		3. DATE PRONOUNCED DEAD	Month 12	Day 23	Year 71	Hour 11:45 A.M.	
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH Sept. 10, 1900	10. AGE (In years last birthday) 74	11. Under 1 Yr. <input type="checkbox"/> Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	E. STREET AND NUMBER 137 E. North Avenue						
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Farmer - Painter, etc.		14B. KIND OF BUSINESS OR INDUSTRY	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) Yes WWI & WWII		17. SOCIAL SECURITY NO. 215-10-1801	18. INFORMANT Friend: Miss Margaret Kelly, 141 E. North Ave.	ADDRESS 21202		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412-9-1</i> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20. MEDICAL CERTIFICATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) _____							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (In Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Peter Lipkovic, M.D.</i>		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/24/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71		24C. NAME OF CEMETERY or CREMATORIAL Gettysburg National Cemetery, Gettysburg, Penna.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR <i>S. J. L. A.D.</i>		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. NORTH AVE.		ADDRESS 21201			



# FUNERAL DIRECTOR: IMPORTANT

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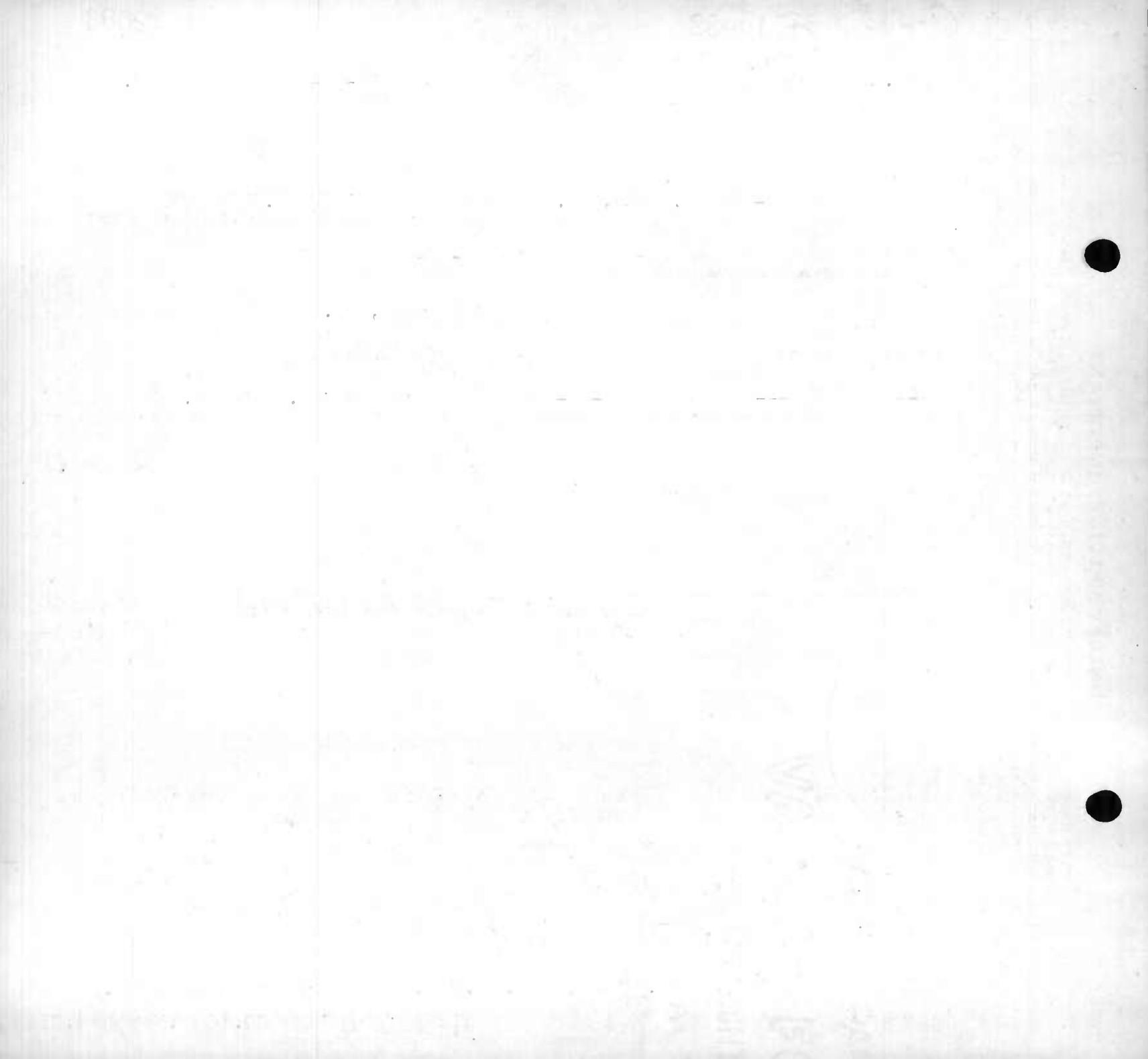
M-252		71 12092	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12093		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		Sister Anna McGinnis		2. DATE AND HOUR OF DEATH December 29, 1971      6:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland		B. COUNTY City		2841	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
94 Villa Saint Michael		E. STREET AND NUMBER 4000 Forest Hill Road		21207			
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1898	9. AGE (in years last birthday) 73 years	10. KIND OF BUSINESS OR INDUSTRY Sister of Charity	11. BIRTHPLACE (State or foreign country) County Armagh, Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse - retired		10B. SOCIAL SECURITY NO. 219-54-0602-J1		14. MOTHER'S MAIDEN NAME Elizabeth Kane			
13. FATHER'S NAME James McGinnis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-0602-J1		17. INFORMANT Sister Andrea      ADDRESS same address	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) IMMEDIATE CAUSE Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF:							
(B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December, 1962 to December, 1971 that (I) (we) last saw the deceased alive on December 28, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Damian P. Alagia</i>		23B. DATE SIGNED December 30, 1971					
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.		23D. DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery		24D. LOCATION (City, town, or county) Emmitsburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Ralph E. Yule		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. NorthAv. 1		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

M.-244 C-200 71 12093  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			REG. NO. 71 12093		
1. NAME OF DECEASED (Type or Print) <b>Mrs. Katherine Causey</b>		2. DATE AND HOUR OF DEATH <b>12-30-71</b>			6.00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2713</b>					
Keswick Home for Incurables of Baltimore City - 700 W. 40th. St.		C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12-17-93</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>78</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Boone</b>		14. MOTHER'S MAIDEN NAME <b>Marjorie Hersh</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>215-48-8980</b>		17. INFORMANT <b>Keswick</b>		ADDRESS <b>700 W. 40th St.</b>	
18. <b>486X</b> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Cerebral arteriosclerosis (senility)</b> <b>Bladder stones</b>							
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>6/13/56</b> to <b>12/30/71</b> 19 to 19, and that in <b>(I)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(We) (did) (not) view the body after death.</b>							
23A. SIGNATURE <b>W.B. Daniels, Jr. M.D.</b>		23B. DEGREE <b>Attending Phys. Med. Director Staff Phys.</b>		23B. DATE SIGNED <b>12/31/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>W. B. DANIELS, Jr.</b>		23D. ADDRESS <b>Keswick</b>		24D. LOCATION (City, town, or county) (State) <b>Garrison Forest, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN. 28/1/72</b>		24C. NAME OF CEMETERY or CREMATORIAL <b>St. Thomas' Ep. Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Garrison Forest, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert S. Miller, Jr.</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>		ADDRESS <b>108 W. North Av. City</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-534		71 12094	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12094	
BIRTH NO.		CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				
Pendleton, Revella		December 30, 1971 5 15 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
FULDYSON HOSPITAL		A. STATE	Md. Baltimore 2562			
FULDYSON HOSPITAL		B. COUNTY				
39 FULDYSON HOSP.		C. CITY OR TOWN	D. INSIDE CITY LIMITS?			
		E. STREET AND NUMBER	YES <input type="checkbox"/> NO <input type="checkbox"/>			
		879 Bethune St.				
5. SEX		6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 69	
F		N		5-31-04	If Under 1 Yr. Months: Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY				
		11. BIRTHPLACE (State or foreign country) N. Va				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Harvey Pat St.						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.				
No		220-03-18419				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, ospheno, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic Heart Disease				
ANTECEDENT CAUSES		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						
II						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
21A. MEDICAL CERTIFICATION		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPST? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					(If in Baltimore City, give exact location)	
21C. WHERE DID INJURY OCCUR?						
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12-1 19 71 to 12-30 19 71 that (1) (we) last saw the deceased alive on 12-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.						
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
Vadhana Chitravlee				Dec. 30 71		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				
Vadhana Chitravlee		Proudent Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORIAL DEGREE	24D. LOCATION (City, town, or county)	(State)	
Burial		1-3-72	Mt. Auburn	Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
JAN 3 1972 Robert E. Taylor, Jr.			J. Daubright	1700 Edmondson Ave.		
VS 150-REV. 1/1/68						



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

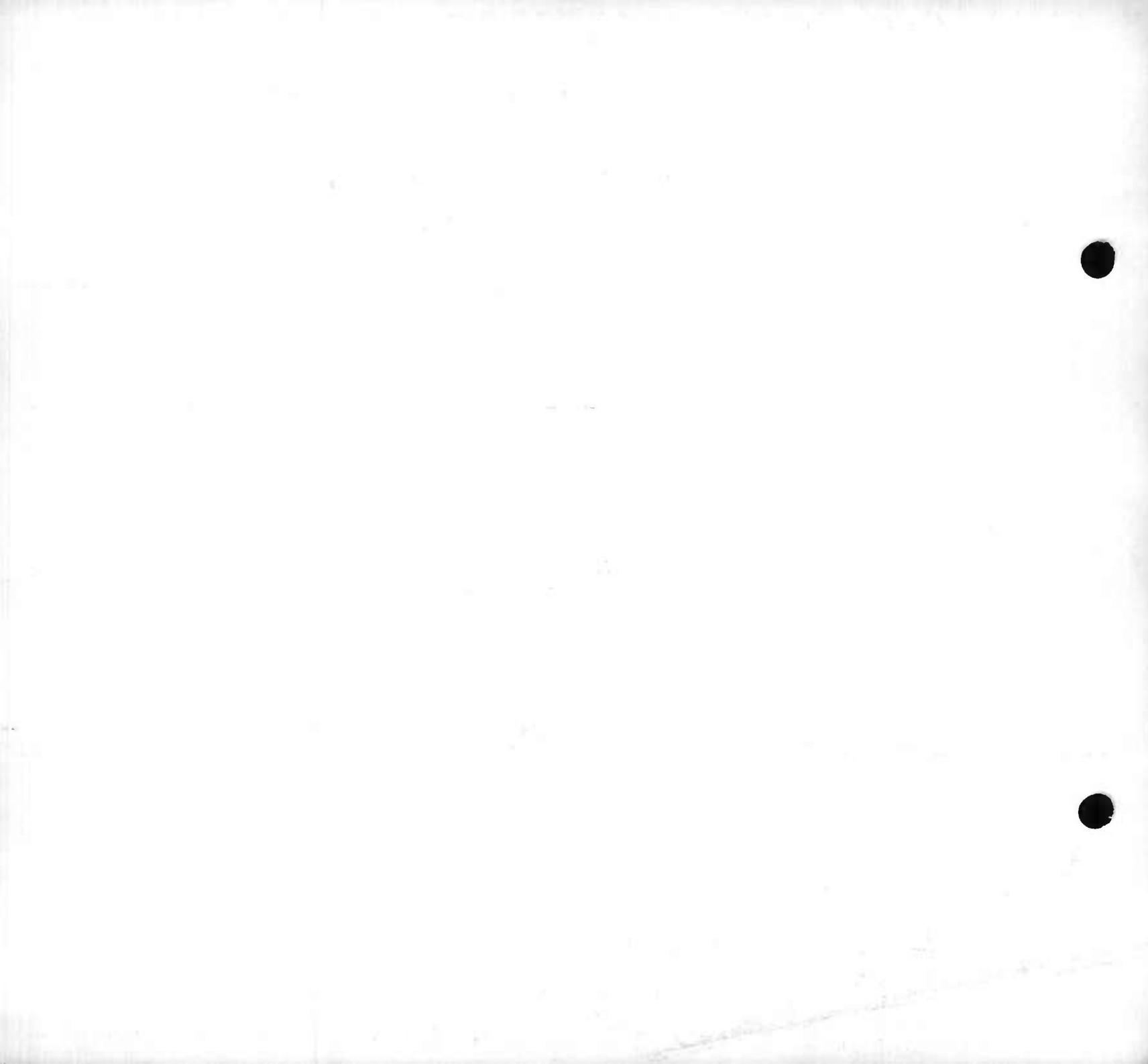
S-162		71 12095	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____		71 12095			
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 12/25/71 8:00 P.M.						
1. NAME OF DECEASED (Type or Print) <b>Joseph Spears</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University of Maryland Hospital</b> <b>38</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE & COUNTY <b>Md</b> C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>1402</b>				
5. SEX <b>M</b>		6. RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/15/18</b>		9. AGE (In years lost birthday) <b>53</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>??? Miss Joan Spears, 810 W Saratoga St</b>				
13. FATHER'S NAME <b>?????</b>		14. MOTHER'S MAIDEN NAME <b>?????</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>237-16-3704</b>		16. SOCIAL SECURITY NO. <b>18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>10/15</b></b>			17. INFORMANT <b>Perforated Gastric &amp; Duodenal Ulcers</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>30 Days</b>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <b>(If in Baltimore City, give exact location)</b>		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (This Hospital) attended the deceased from <b>November 27 1971</b> to <b>December 25 1971</b> that (I) (We) last saw the deceased alive on <b>December 25 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Richard A. Tomasulo M.D.</b>		23B. DATE SIGNED <b>Dec 25, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>Richard A. Tomasulo M.D.</b>		23D. ADDRESS <b>Univ. of Maryland Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) <b>A A County Md</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. Jr. M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Ave</b>		ADDRESS <b>VS 150-REV. 1/1/68</b>				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

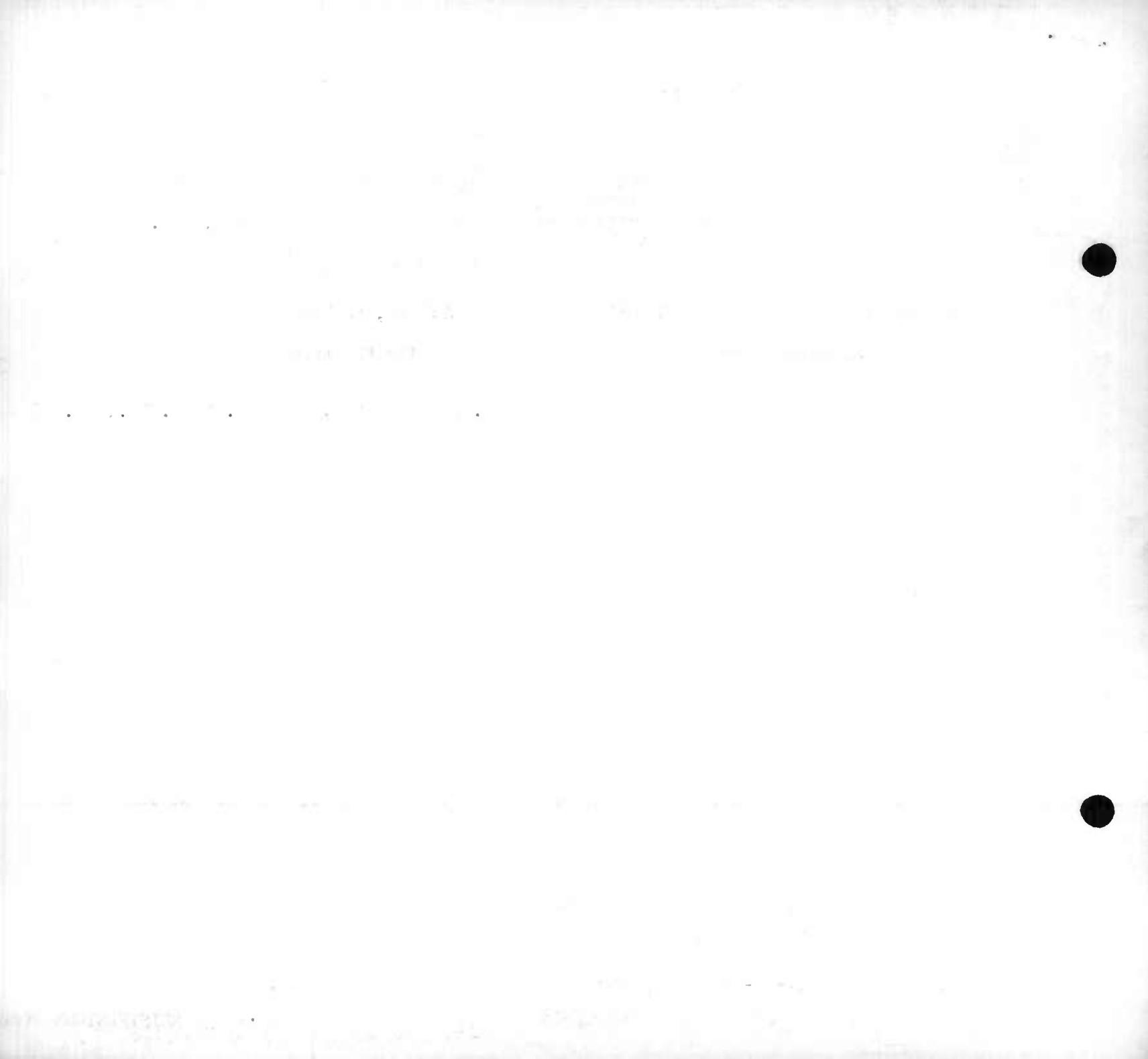
W-435		71 12096		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12096	
BIRTH NO.		James Walton (A) (H)		2. DATE AND HOUR OF DEATH 12/29/71		12:40 P.M.			
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  38 University of Md. Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY 1602					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Union S.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME George Walton		14. MOTHER'S MAIDEN NAME Malinda							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-1955		17. INFORMANT Mr Robert Walton, 1011 Somerset St		ADDRESS Philadelphia			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(c) Cancer of the Right Lung 6 mo -					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 12/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of lung		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX.		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/23/71 to 12/29/71 that (I) (we) last saw the deceased alive on 12/29/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Louis E. Grenzer		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/29/71					
23C. PHYSICIAN'S NAME (Type) Louis E. GRENZER		23D. ADDRESS							
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY or CREATORY Spartenberg		24D. LOCATION (City, town, or county) South Carolina			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF RELEASER Dr. Louis E. Grenzer		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave			



## **FUNERAL DIRECTOR: IMPORTANT**

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M-534 71 12097		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12097
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Mary Mandel</u>		2. DATE AND HOUR OF DEATH <u>27 Dec 1971</u> 7:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hospital</u> ADDRESS OR LOCATION <u>5601 Loch Raven Blvd. Baltimore 21239</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2730</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u> 6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Jan 1906</u>	9. AGE (in years last birthday) <u>65</u> If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>BERNARD KERNS</u>		14. MOTHER'S MAIDEN NAME <u>IDA PETERSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service. <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-6383</u>	17. INFORMANT <u>MR. DAVID MANDEL, 7111 PK.HGHTS.AVE., APT.807</u>	ADDRESS
18. I <u>✓</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH <u>Carcinoma of Breast, metastatic</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 3 yrs</u>		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> 19 <u>71</u> to <u>12/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Richard J. Owellen MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>12/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard J. Owellen</u>		23D. ADDRESS <u>5601 Loch Raven Blvd. Baltimore Md 21239</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE <u>12-28-71</u>	24C. NAME OF CEMETERY OR CREMATORIUM <u>OHEL YAKOV</u>	24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>	(State)
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 8 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>	25C. FUNERAL DIRECTOR <u>Sol Levinson</u>	BROS. 6010 REISTERSTOWN ROAD & XXXXXXXXXX XXXXXXXXX	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-150/1 12088		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12098</u>	
BIRTH NO.		2. DATE AND HOUR OF DEATH <u>12/07/71</u>		M. <u>2:20 A.</u>	
1. NAME OF DECEASED (Type or Print) <u>RUBIN, MICHAEL</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Hospital Hosp. of Baltimore, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Hospital Hosp. of Baltimore, Inc.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost birthday) <u>67</u>		If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>	
13. FATHER'S NAME <u>ALEXANDER RUBIN</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL ?</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-32-8312</u>		17. INFORMANT <u>MRS. JULIA RUBIN, 5939 WESTERN PARK DRIVE #9</u>	
18. <u>412-31-9509</u>		CAUSE OF DEATH  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>  <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>no. days</u>	
II		(A) IMMEDIATE CAUSE <u>Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>no. yrs.</u>	
(B) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>no. yrs.</u>			
(C) <u>ASCPD (Arteriosclerotic Heart Disease)</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>no. yrs.</u>			
III		<u>Diabetes Mellitus, CHF</u>		<u>no. yrs.</u>	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-6</u> to <u>12-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-07</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Veronica C. Germino</u>		23B. DEGREE <u>Attending Phys.</u> <input type="checkbox"/>		23C. MEDICAL STAFF Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23D. ADDRESS <u>Hospital Hosp. of Baltimore</u>		23E. DATE SIGNED <u>12/27/71</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-28-71</u>		24C. NAME OF CEMETERY OR CREMATORIAL <u>BOBROISKER BENEFICIAL CIRCLE, ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jacob, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	
ADDRESS <u>ADDRESS</u>					

17. 2. 22. 1977. 10. 22.

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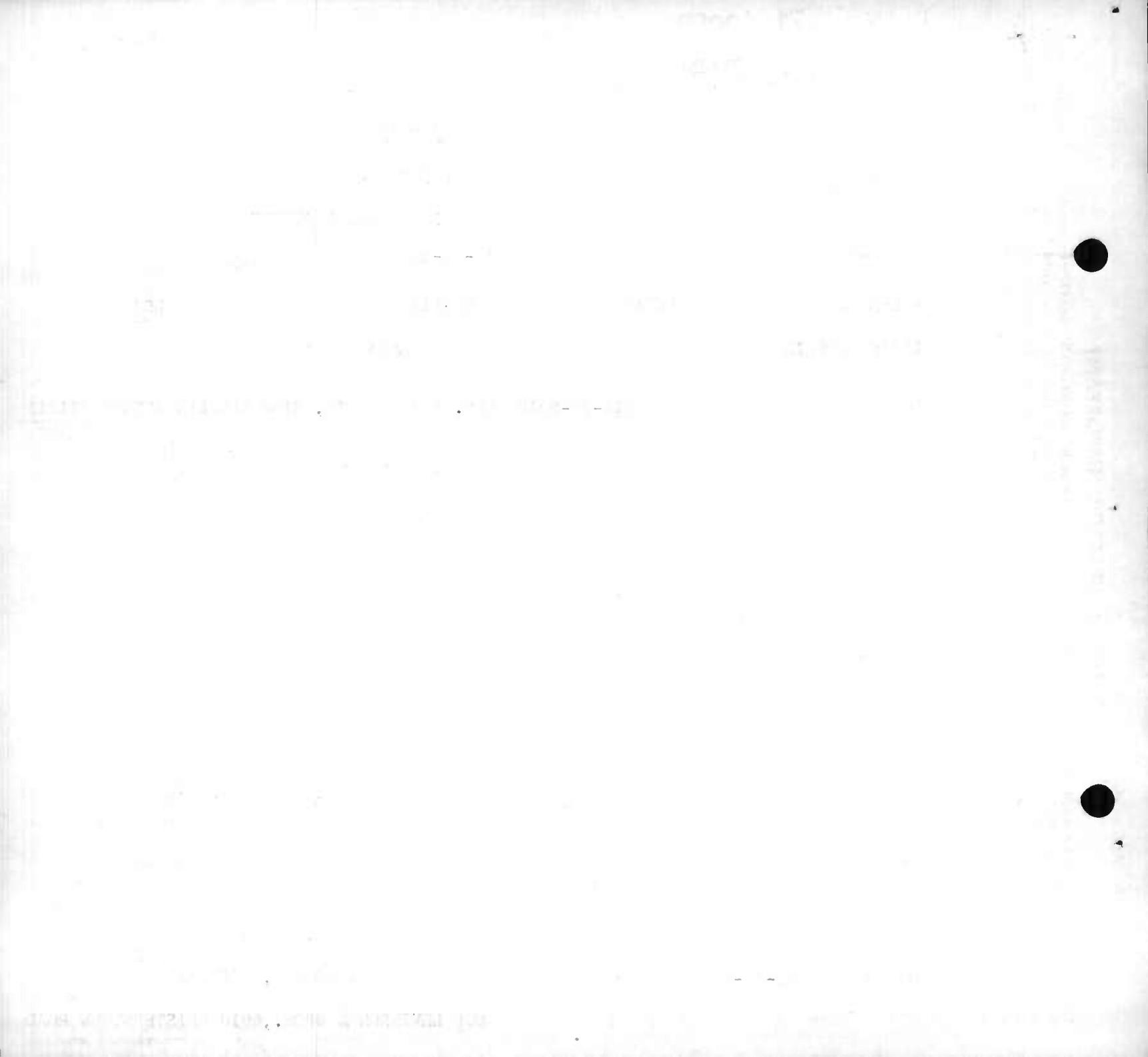
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-625 71 12099		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12099	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/26/71 17:15 P.M.			
1. NAME OF DECEASED (Type or Print) <b>IRVING Dworkin</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 283	
FULL NAME OF HOSPITAL OR INSTITUTION <b>+2 SINAI HOSPITAL</b>		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 4100 NEWBURN AVENUE	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-25-1906		9. AGE (in years last birthday) 65		If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>ISAAC DWORKIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ?</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-9049</b>		17. INFORMANT <b>MRS. IDA DWORKIN, 4100 NEWBURN AVENUE #21215</b>	
18. <b>410-94-2509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ASHD + Diabetes</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his/hospital) attended the deceased from _____ 19 60 to 17/26 19 71 that (I) (we) last saw the deceased alive on 12/15 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Leonard M. Lister</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/26/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leonard M. Lister MD</b>		23D. ADDRESS <b>711 Park Heights Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-28-71</b>		24C. NAME of CEMETERY or CREMATORIAL <b>BETH JACOB</b>	
				24D. LOCATION <b>FINKSBURG, MARYLAND</b>	
25A. DEPT. OF M.D. & M.H.D. DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Vivian F. Jacob</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-450		71 12100	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12100		
BIRTH NO.				2. DATE AND HOUR OF DEATH 12/28/71 5:19 P.M.			
1. NAME OF DECEASED (Type or Print)		GENEVIEVE Flynn		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Balto. B. COUNTY BALTO			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South 3001		(If not in hospital or institution, give street address or location) Balto General Hosp So. Hanover St		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6-28-27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		9. AGE (in years last birthday) 44		If Under 1 Yr., Months Days Hours Min.	
13. FATHER'S NAME JAMES		14. MOTHER'S MAIDEN NAME Brown Lillian		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 247-44-0969		17. INFORMANT Elsie I. Clemon		ADDRESS Elizabeth Rd	
18. I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) METASTATIC CA OF CERVIX DUE TO, OR AS A CONSEQUENCE OF:					
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
(O)							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 27 1971 to Dec. 28 1971 that (I) (we) last saw the deceased alive on Dec. 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Geo. Juh Noh M.D.		23B. DATE SIGNED Dec 28/71					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Park		24D. LOCATION (City, town, or county) Glen Burnie, Md.	
Burial							
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Walsh Jr.		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.	

the most important suggestion

71 12101

BALTIMORE CITY HEALTH DEPARTMENT

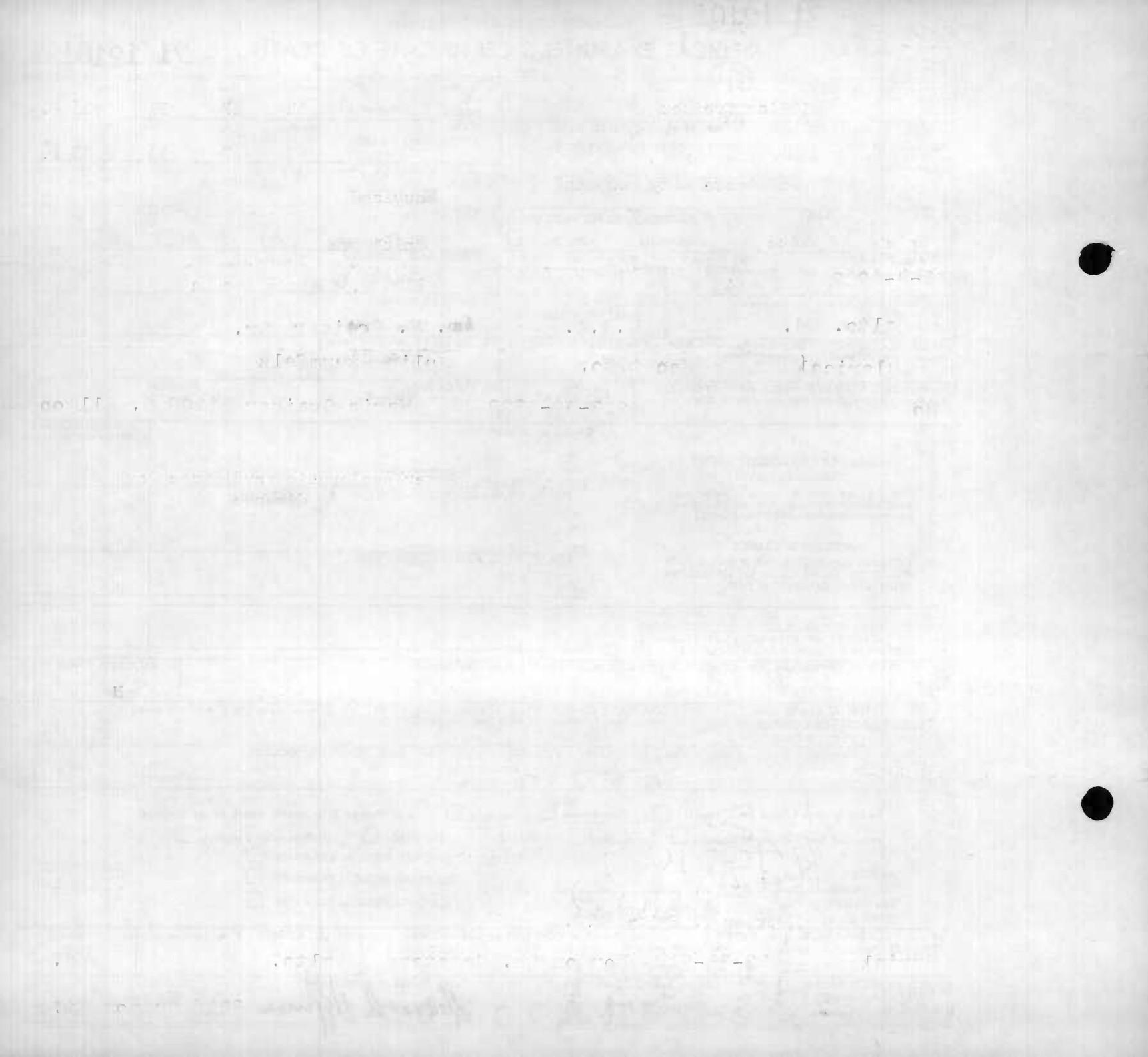
G-626

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12101

BIRTH NO.

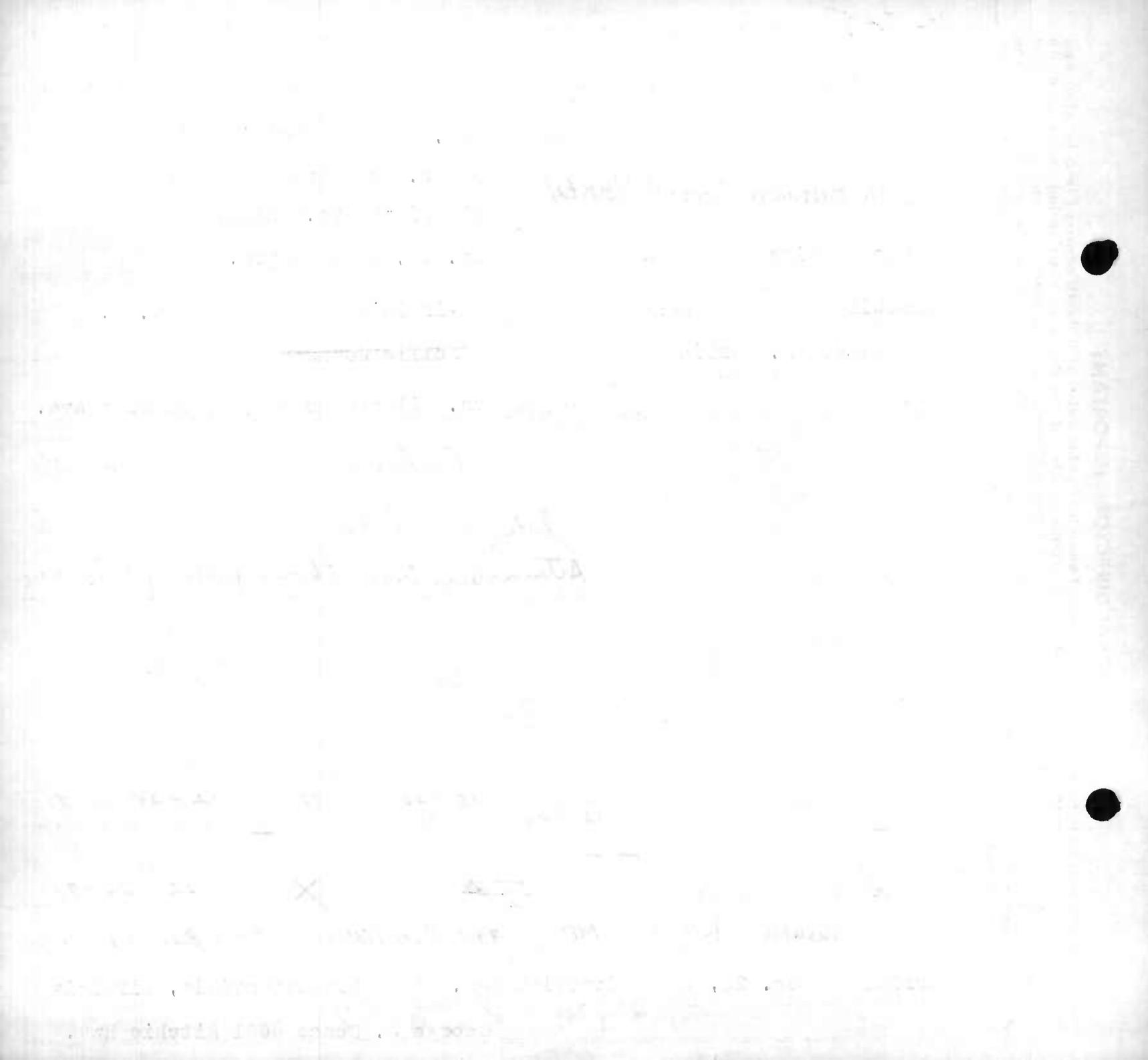
1. NAME OF DECEASED (Type or Print)		William Greiser		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 27	Year 71	Hour 9:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Baltimore City Hospital		3. DATE PRONOUNCED DEAD	Month	Day	Year	Hour	
					12	27	71	9:25 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
A. STATE		B. COUNTY							
Maryland		101							
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	C. CITY OR TOWN	D. INSIDE CITY LIMITS?			
Male	White				Baltimore	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		
9. DATE OF BIRTH	10. AGE (In years lost birthday)	If Under 1 Yr. <input type="checkbox"/> II Under 24 Hrs. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	E. STREET AND NUMBER						
1-4-1907	64		1109 S. Ellwood Avenue						
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME						
Balto. Md.	U.S.A.		Wm. E. Greiser Sr.						
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME						
Clerical	Hecht Co.		Julia Sturmfelz						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS				
NO	213-09-7379		Marie Greiser		1109 S. Ellwood				
19. CAUSE OF DEATH									
(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____									
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21. AUTOPSY? (Yes or No) No									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)			22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORIY		24D. LOCATION		(City, town, or county)	(State)	
Burial		12-31-71	Loudon Pk. Cemetery		Balto.		Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR		ADDRESS		
JAN 3 1972 Robert E. Sabey, M.D.		D. O. N. H. Hoffman			H. Hoffman		3218 Hudson St.		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

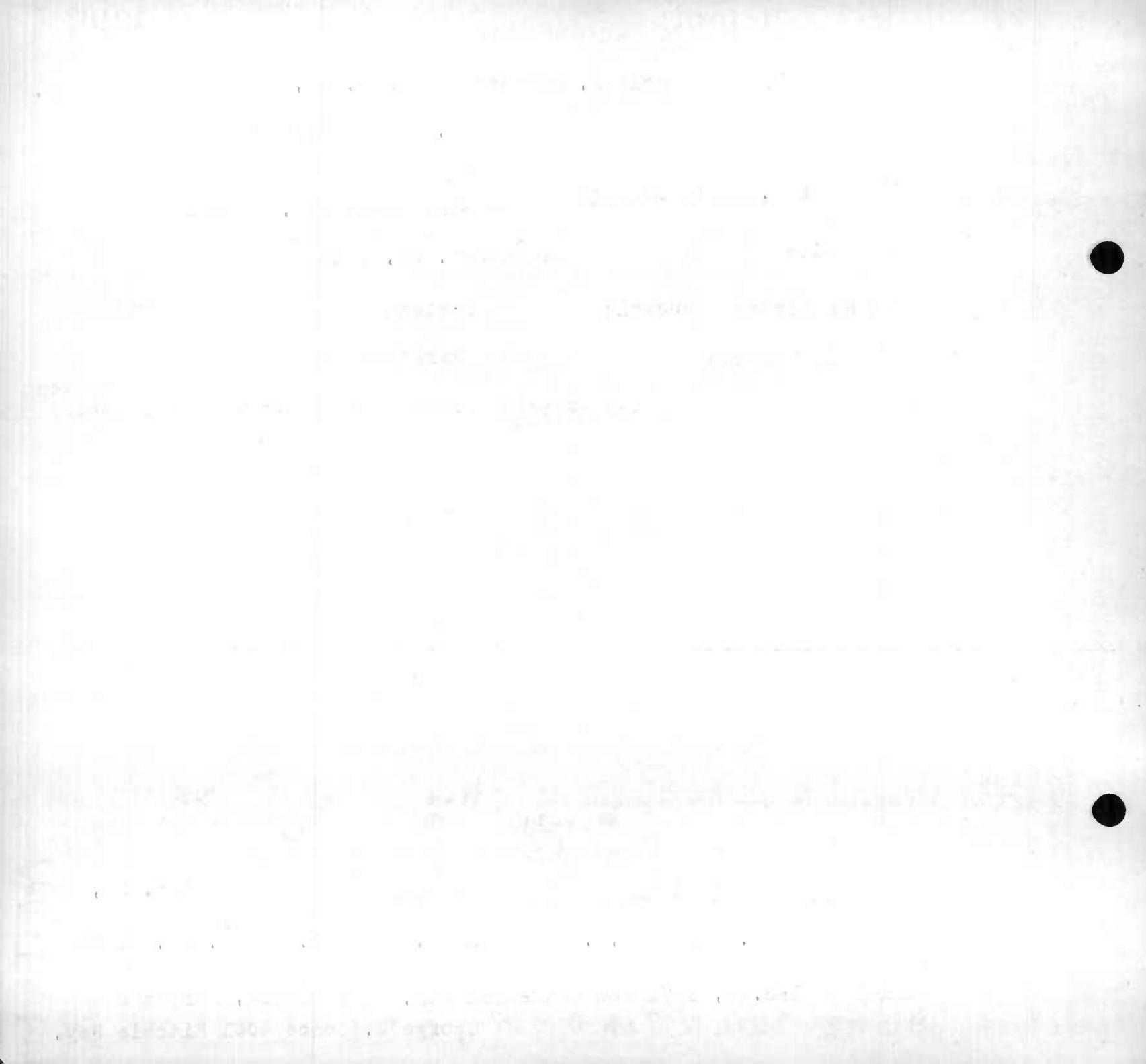
K-530 BIRTH NO. 71 12102		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12102
1. NAME OF DECEASED (Type or Print) <b>Lucille M. Kennedy</b>		2. DATE AND HOUR OF DEATH <b>12 - 25 - 71</b>		8:00 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore 5300</b> C. CITY OR TOWN <b>Balto. Suburban</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		9. AGE (In years lost birthday) <b>61 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Samuel A. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Johnson</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226 07 2103</b>		17. INFORMANT <b>Mrs. Mildred McGee</b>
18. CAUSE OF DEATH <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>		ADDRESS <b>3 months</b>		
(A) IMMEDIATE CAUSE <b>Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Intestinal fistula</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>		
(C) <b>Atenodochus, true - Chro. pyloriphitis, severe</b>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Identify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>10 - 20</b> 19 <b>71</b> to <b>12 - 25</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>12 - 25</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Susumu Kinjo</b>		23B. DATE SIGNED <b>12 - 25 - 71</b>		23C. PHYSICIAN'S NAME (Type) <b>SUSUMU Kinjo MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 28, 1971</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>Riverview Cem.</b>
24D. LOCATION (City, town, or county) <b>Charlottesville, Virginia</b>		24E. DEGREE <b>DEGREE</b>		
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 8 1972</b>		25B. NAME OF REGISTRAR <b>George E. Nease</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hwy.</b>



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12103	BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12103		
1. NAME OF DECEASED (Type or Print)		Mary Francis X. Mahoney				2. DATE AND HOUR OF DEATH Dec. 25, 1971 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD									
FULL NAME OF HOSPITAL OR INSTITUTION <i>40</i>		(If not in hospital or institution, give street address or location) <i>St. Agnes Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
						C. CITY OR TOWN <b>Halethorpe</b>			
						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
						E. STREET AND NUMBER <b>4100 Maple Ave.</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1887 84</b>		9. AGE (In years last birthday) II Under 1 Yr. Months Days Hours Min. II Under 24 Hrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious Sister</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>			
13. FATHER'S NAME <b>Martin Mahoney</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Murray</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>199 40 5665</b>		17. INFORMANT <b>Sister Mary Dolores Good Shepherd</b>		ADDRESS <b>Convent</b>			
18. <i>431.9</i>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i> cerebral hemorrhage</i> <i> cerebral arterioclerosis</i>			
						(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
						(C) _____			
II									
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 21</b> 1971 to <b>Dec.</b> 1971, and that (I) (we) last saw the deceased alive on <b>Dec. 21</b> 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Aidan E. Walsh</i>		23B. DATE SIGNED <b>Dec. 27, 1971</b>							
23C. PHYSICIAN'S NAME (Type) <b>Aidan E. Walsh M.D.</b>		23D. ADDRESS <b>222 St. Paul St. Balto. Md. 21202</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 28, 1971</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <i>Robert E. Walsh, M.D.</i>		25C. FUNERAL DIRECTOR <b>George J. Goncze</b>		ADDRESS <b>4001 Ritchie Hwy.</b>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-615 71 12104		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12104
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12-30-71 12 <sup>36</sup> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE & COUNTY 2934 Edmondson Ave 1606 C. CITY OR TOWN Baltimore E. STREET AND NUMBER		
Lutheran Hospital of Md 730 Ashburton St		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male Negro	6. RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1887	9. AGE (in years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed	10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Stephen Carpenter		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME Unkn.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT Ella Carpenter Vernita Robinson		
		A. S. H. D.		
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 12-23-71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-23-1971 to 12-30-1971 that (I) (we) last saw the deceased alive on 12-23-1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Barby Calin		Attending Phys. <input checked="" type="checkbox"/> Degree	Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Degree	23B. DATE SIGNED 12-31-71
23C. PHYSICIAN'S NAME (Type) BARBY CALIN		23D. ADDRESS 831 Poplar Grove Blvd.		
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 1/3/72	24C. NAME OF CEMETERY OR CREMATORIAL Carver Memorial Park		24D. LOCATION (City, town, or county) Laurel, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Sally K. D.		25C. FUNERAL DIRECTOR J. MCINTOSH & DYETT
ADDRESS 1701 LAURENS ST.				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-420		71 12105		BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH		REG. NO. 71 12105	
BIRTH NO.				2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>MILUKAS, Anna</u>				12/27/71 1 1-15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTH CHARLES GEN'L HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>49</u>		A. STATE <u>M.D.</u>	B. COUNTY <u>BALTIMORE</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/94</u>	9. AGE (in years lost birthday) <u>77</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>PENNSYLVANIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>25A</u>			
13. FATHER'S NAME <u>STANLEY MILUKAS</u>				14. MOTHER'S MAIDEN NAME <u>ZENTKOWNA</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>195-09-8196</u>		17. INFORMANT	ADDRESS			
18. <u>124X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>Cancerous of Breasts &amp; generalized metastasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Breasts &amp; generalized metastasis</u>						
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u></u>						
		(C) _____						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>(If in Baltimore City, give exact location)</u>				
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>12/18/71</u> to <u>12/27/71</u> that (I) (we) last saw the deceased alive on <u>12/27/71</u> 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>Veena Sathirakul, M.D.</u>		DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <u>12/27/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>VEENA</u>		23D. ADDRESS <u>North Charles Gen. Hosp</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/71</u>		24C. NAME of CEMETERY or CREMATORIUM <u>St. Casimirs</u>		24D. LOCATION (City, town, or county) <u>Muhlenberg</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>00000000000000000000000000000000</u>		25C. FUNERAL DIRECTOR <u>William E. Johnson</u>		ADDRESS <u>Balto, Md.</u>		

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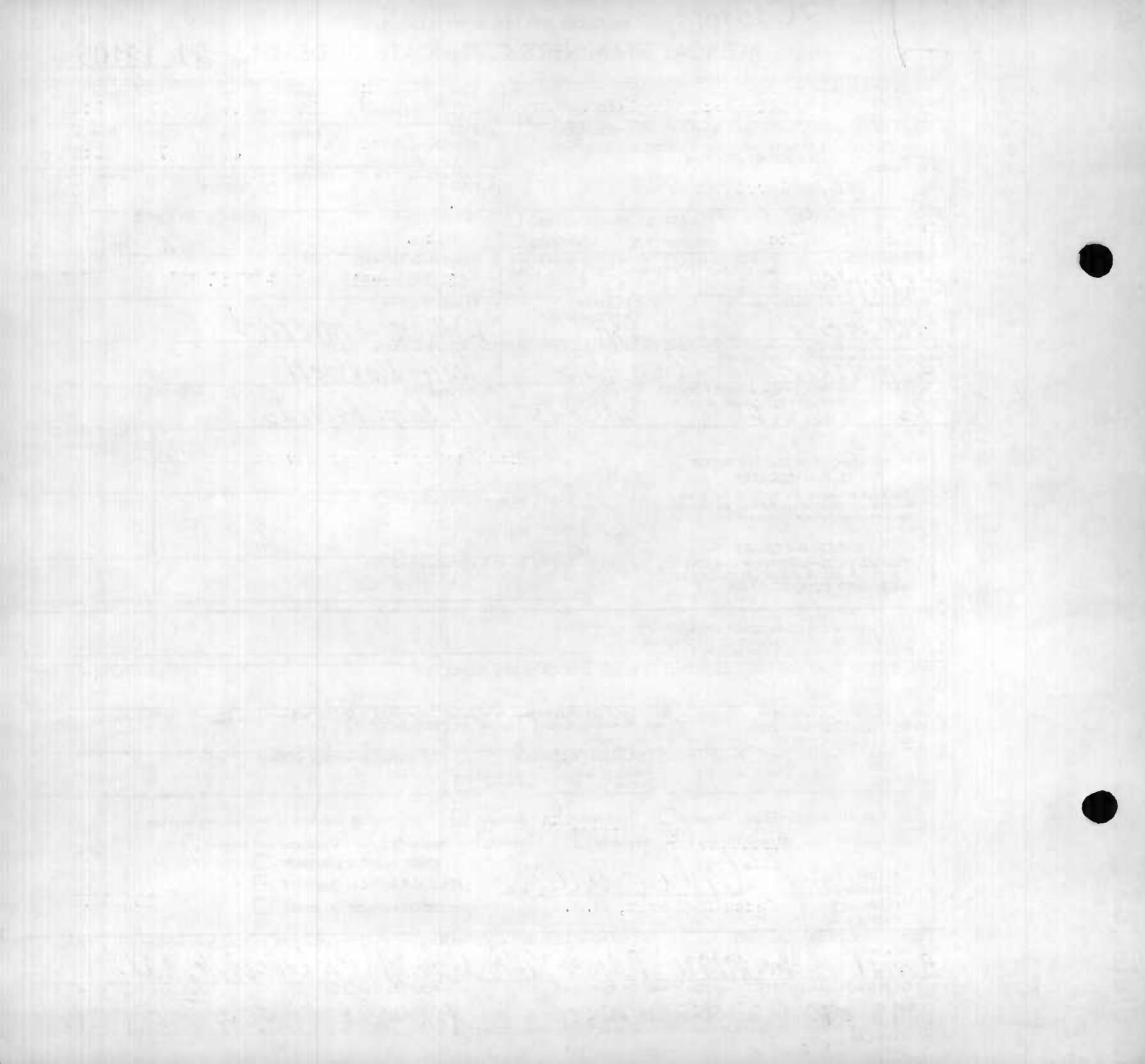
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12106

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Elizabeth Virginia Jessop		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 24	Year 71	Hour 11:20 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5409 Sarril Road		3. DATE PRONOUNCED DEAD	Month 12	Day 24	Year 71	Hour 11:20 P.M.
6. SEX female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH OCT. 17, 1900		10. AGE (In years lost birthday) 71	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 5409 Sarril Road - Apt. B				
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF USA	13. FATHER'S NAME William Crawford		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			
15. MOTHER'S MAIDEN NAME Jean Maxwell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes W.W.I		17. SOCIAL SECURITY NO. 212-05-9307	18. INFORMANT Vet. Adm. Records	ADDRESS		
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 29, 1971		24C. NAME of CEMETERY or CREMATORIUM Pulney Valley Memorial		24D. LOCATION (City, town, or county) (State) Cockeysville, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. LaBarre, Jr.		25C. FUNERAL DIRECTOR John Barnes, Son, Funeral, Md.		ADDRESS		



D-400

71 12107

BALTIMORE CITY HEALTH DEPARTMENT

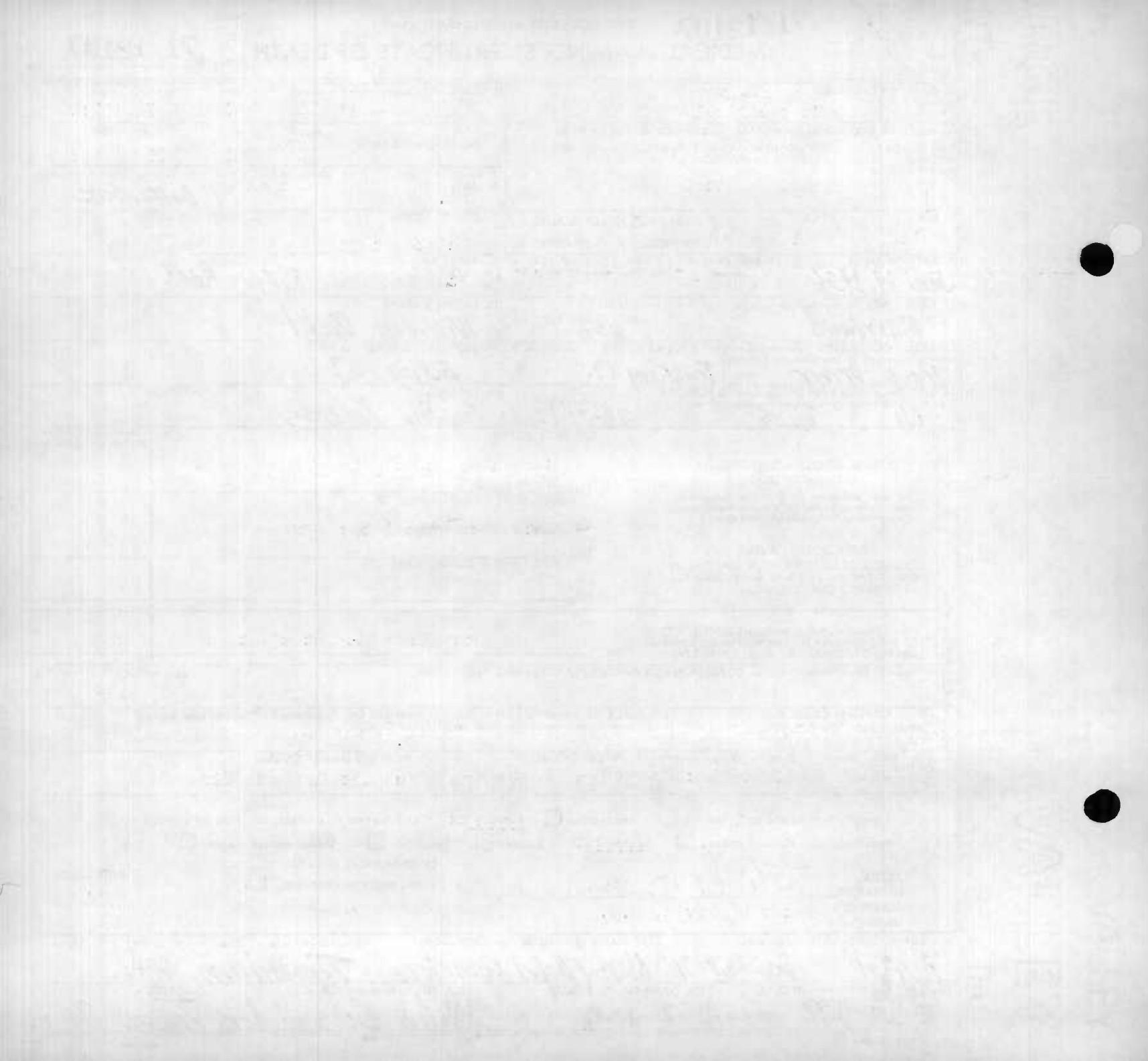
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12107

BIRTH NO.

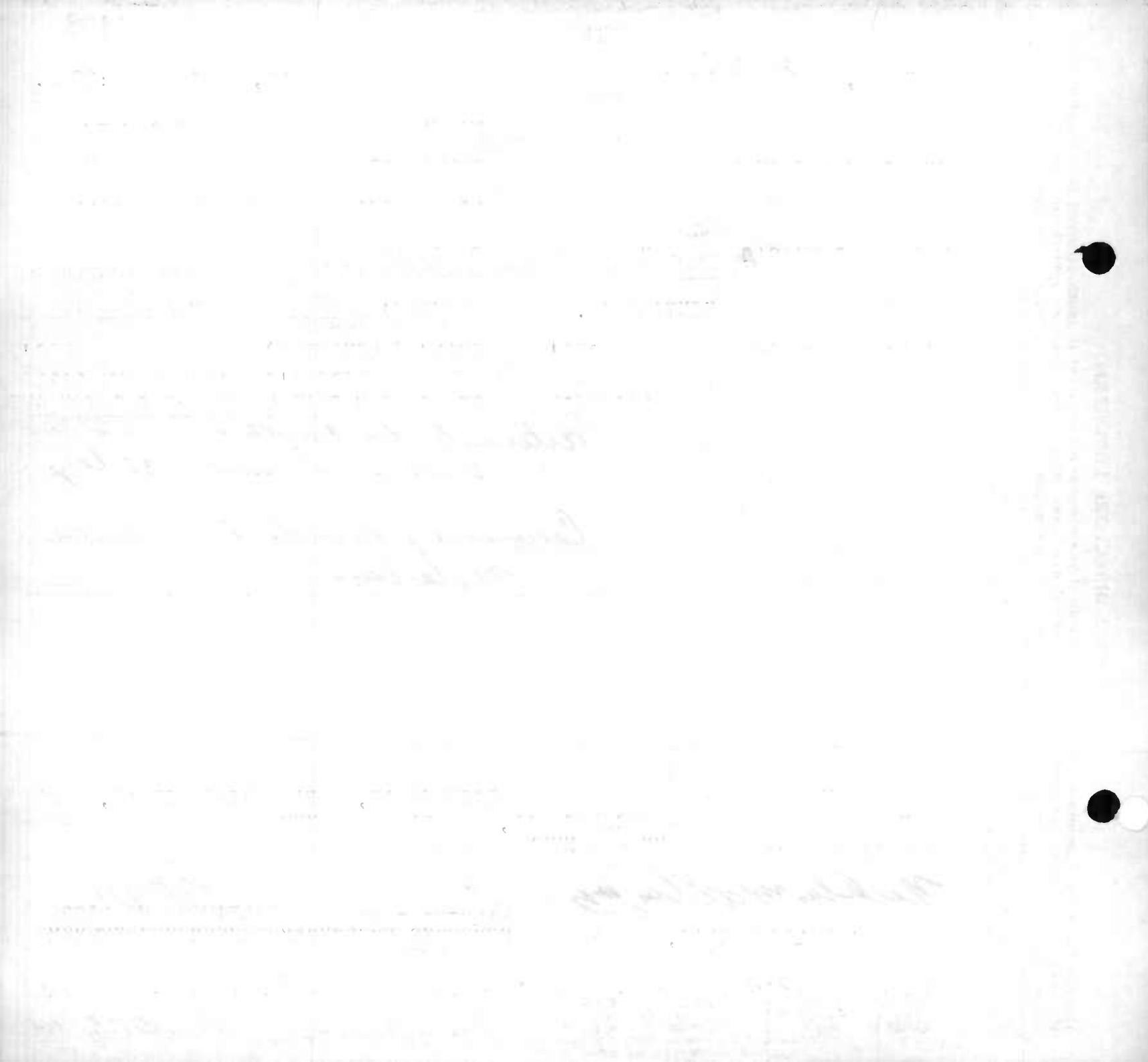
1. NAME OF DECEASED (Type or Print)		LOUIS George Diehl		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 23	Year 71	Hour 11:10 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <small>(If not in hospital or institution, give street address or location)</small>		Sinai Hospital		3. DATE PRONOUNCED DEAD	Month 12	Day 23	Year 71	Hour 11:10 p.m.	
6. SEX male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Reisterstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH Jan. 29, 1936	10. AGE (In years last birthday) 35	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER Rt 1 Box 84A		Ridge Road				
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME William Diehl		15. MOTHER'S MAIDEN NAME Edna ?					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Trucking Co.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No Name			17. SOCIAL SECURITY NO. 218-32-0059	18. INFORMANT Family Records	ADDRESS
19. E 890 X + 303.9		CAUSE OF DEATH Carbon monoxide poisoning					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</small>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)		(C)							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute alcoholic intoxication					21. AUTOPSY? (Yes or No) yes		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 1 Box 84A					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 23 71 10:30 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject in house fire					
<p>23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D.</p> <p>EXAMINER'S NAME (Type) Peter Lipkovic, M.D.</p>									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 28, 1971	24C. NAME OF CEMETERY or CREMATORIUM May's Chapel Cemetery		24D. LOCATION (City, town, or county) Timonium, Md.		(State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR John Burns, Son, Towson, Md.		25C. FUNERAL DIRECTOR John Burns, Son, Towson, Md.		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

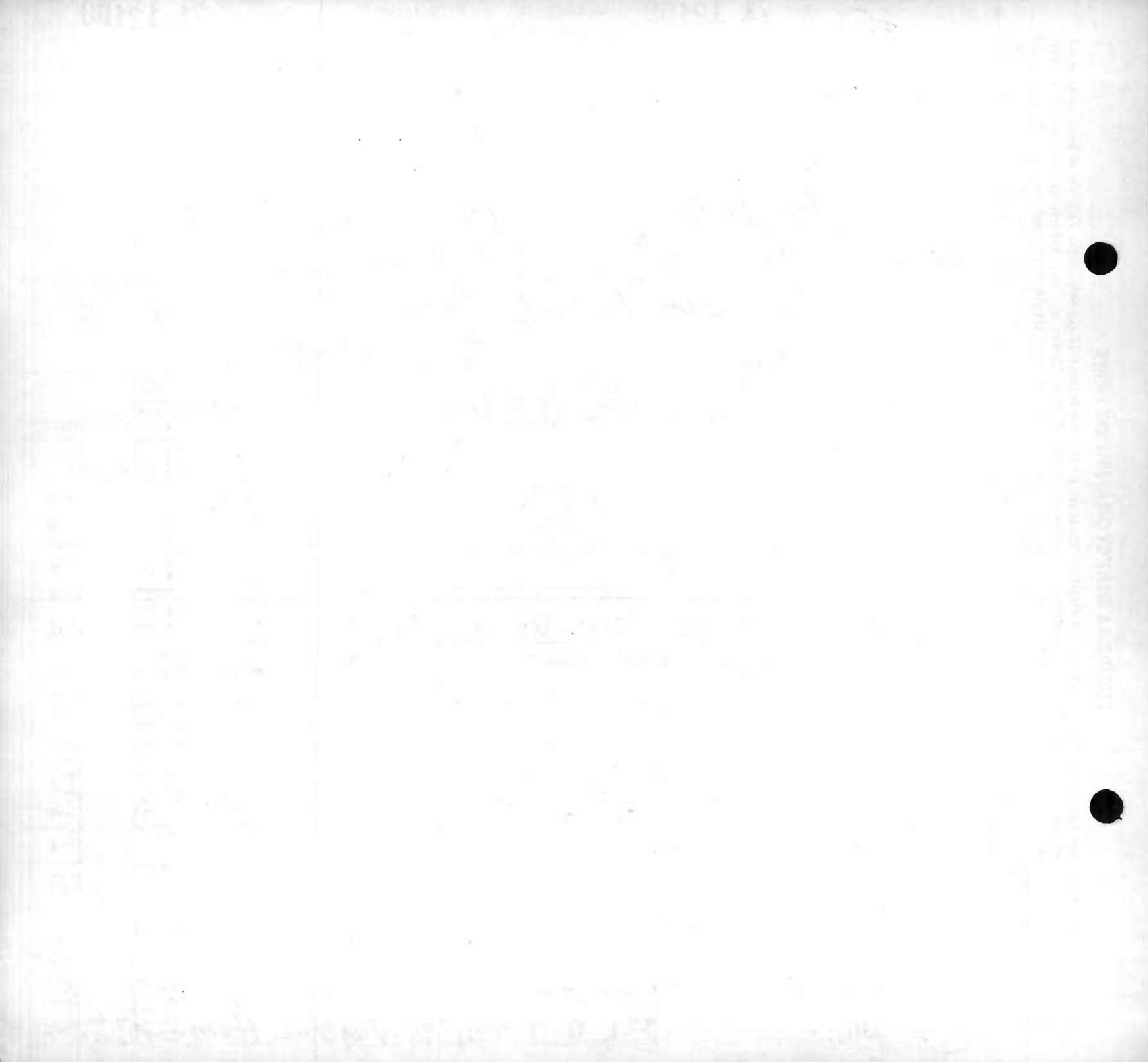
D-100 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12108
1. NAME OF DECEASED (Type) <b>DAYHOFF, EDWARD DORSEY</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 27, 1971</b>		11:20 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b>  <b>40</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY 5300</b>		
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WEAVER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TEXTILE CO.</b>		8. DATE OF BIRTH <b>06 08 92</b>
13. FATHER'S NAME <b>WILLIAM DAYHOFF</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		9. AGE (in years last birthday) <b>79</b>
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213096370</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT  <b>RECORD'S BALTIMORE ADDRESS ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>30 days</b>		
21A. DATE OF OPERATION  <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 17, 1971</b> to <b>DECEMBER 27, 1971</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 27, 1971</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.				
23A. SIGNATURE  <b>Nicholas Mallis, MD</b>		23B. DATE SIGNED  <b>12/28/71</b>		
23C. PHYSICIAN'S NAME (Type)  <b>NICHOLAS MALLIS, MD</b>		23D. ADDRESS  <b>WILKENS &amp; PINE BALTIMORE MD 21229 XXXXXX-XHORXXXXXXRMXXXXXXRXXXXX</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)  <b>Burial</b>		24B. DATE  <b>12-30-71</b>		24C. NAME OF CEMETERY OR CREMATORIAL HGTS
25A. DATE REC'D BY HEALTH DEPT.  <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR  <b>Reg. of the State of Maryland</b>		24D. LOCATION (City, town, or county)  <b>ELLIOTT CITY, MD 21043</b>
25C. FUNERAL DIRECTOR  <b>John Mallis - Mack, Elliott City, Md.</b>		ADDRESS		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

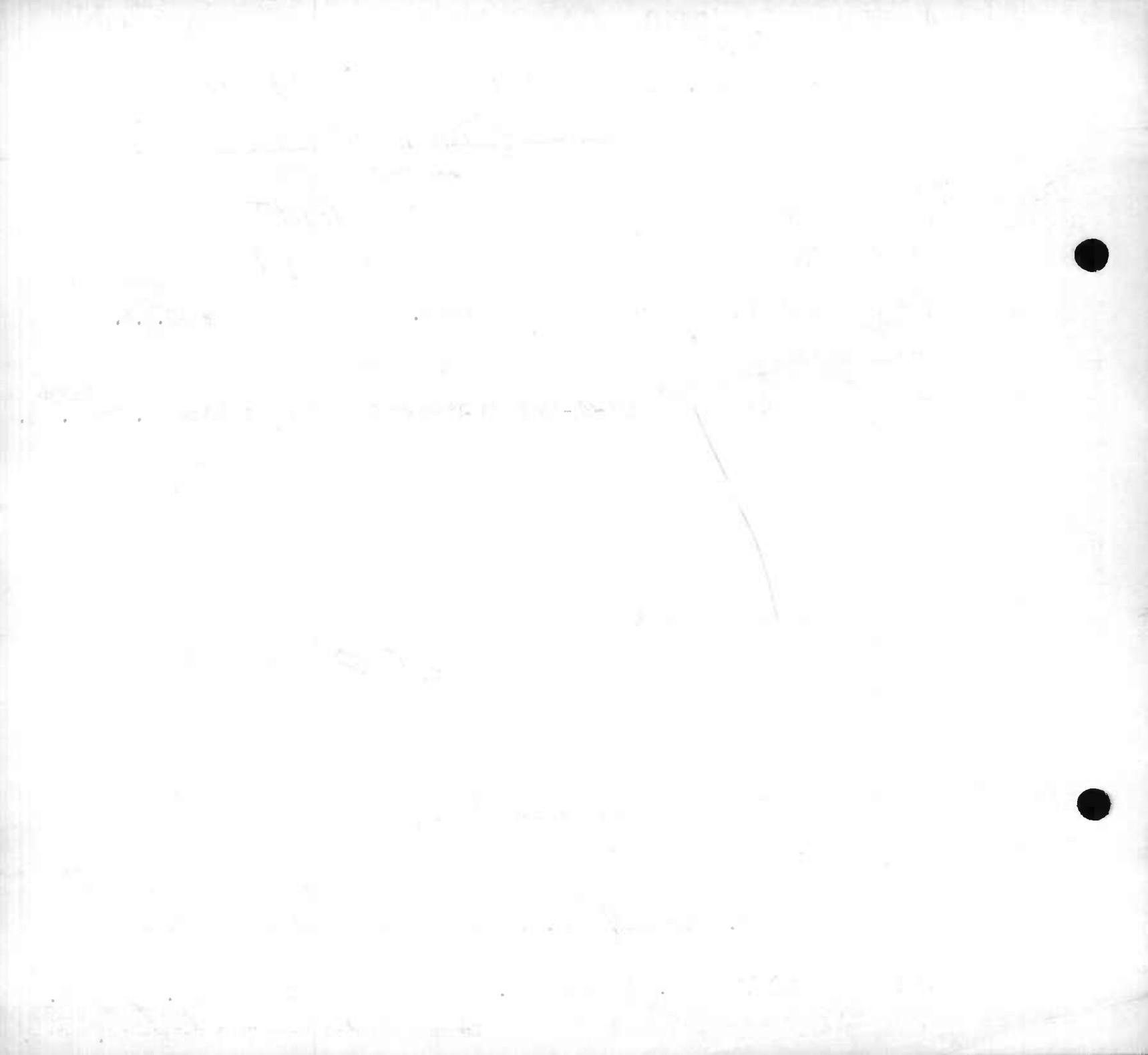
W-650		71 12109	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12109
<b>CERTIFICATE OF DEATH</b>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WYRM Charles Joseph		12-29-71 12 noon		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		
South Baltimore General Hospital		1408 Locust Street		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
A. STATE MARYLAND		B. COUNTY 2505		
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS?		
E. STREET AND NUMBER 1408 Locust Street		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-9-28		9. AGE (in years lost birthday) 43		If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10B. KIND OF BUSINESS OR INDUSTRY Sears' Back		11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles		14. MOTHER'S MAIDEN NAME Jessie McMullen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 161-20-1918		ADDRESS 1408 Locust St.
17. INFORMANT Wife		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs		
18. 410-9142509 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF, Arteriosclerotic Heart Disease Hypertension/Myocardial Infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus by history Several years		
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (In Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Dec. 29 1971 to Dec. 29 1971 that (we) last saw the deceased alive on Dec. 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Colvin C. Carter, MD		Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23B. DATE SIGNED Dec 29, 1971				
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter MD		23D. ADDRESS 3001 S. Hanover St. Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71		24C. NAME OF CEMETERY or CREMATORIAL Cedar Hill
24D. LOCATION Ritchie Hwy BALTO. MD.		(City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR Robert E. Jacoby, M.D.		25C. FUNERAL DIRECTOR Hyatt Funeral Home Peabody
VS 150-REV. 1/1/68		ADDRESS 4200 Peabody		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12110		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12110	
1. NAME OF DECEASED (Type or Print)		MARY M. Janitzky		CERTIFICATE OF DEATH		X	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		33 Johns Hopkins Hosp.		2. DATE AND HOUR OF DEATH		12-29-71 12:30 A.M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Md. B. COUNTY Baltimore	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-29-24 9. AGE (in years last birthday) 97	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Reg. Nurse Nursing		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harold Boughton		14. MOTHER'S MAIDEN NAME Mary McDonough		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 180-24-8675	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH  189.01 METASTATIC CARCINOMA OF ENDOMETRIUM		17. INFORMANT William Janitzky 4118 Kahlston Rd. Balto. Md.		ADDRESS 21236	
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		DISEASE OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES		(C) _____		(If in Baltimore City, give exact location)		(If in Baltimore City, give exact location)	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		23. MEDICAL CERTIFICATION		24. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27C. WHERE DID INJURY OCCUR?		20A. AUTOPSY? Yes <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		29E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
30. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.		31. SIGNATURE Karen B. Strauss		32. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		33B. DATE SIGNED 12-29-71	
33C. PHYSICIAN'S NAME (Type) Karen B. Strauss, M.D.		33D. ADDRESS The Johns Hopkins Hospital		34A. BURIAL CREMATION, REMOVAL (Specify) Burial		34B. DATE 1/3/72	
34C. NAME OF CEMETERY OR CREMATORIUM St. Michaels Luth. Cemetery		34D. LOCATION Perry Hall Balto. Md.		35A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		35B. NAME OF REGISTRAR Robert J. Johnson	
35C. FUNERAL DIRECTOR Hassan Funeral Home		35D. ADDRESS 7401 Belair Rd. Balto.		36. (State) Md.			



U-536

71 12111

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

X 71 12111

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Preston Underwood

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
31  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospital

2. DATE Known  Month Day Year Hour  
OF DEATH Estimated  12 27 71 2:30 P.M.3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 27 71 2:30 P.M.

## 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY BALTIMORE

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?  
YES  X NO 6. SEX Male 7. RACE White 8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 9. DATE OF BIRTH March 5, 1957 10. AGE (In years  
lost birthday) XX 14 If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF  
WHAT COUNTRY? U.S.A.E. STREET AND NUMBER  
2704 W. Woodwell Road14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)  
Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME  
Dorothy Sluss16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
No 17. SOCIAL SECURITY NO. Unknown18. INFORMANT ADDRESS  
Rose&Quesenberry Funeral Home W., Va.

19. E 814.7 CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE Multiple body injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Street Merritt Blvd, 310' N. of Ives Lane

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12 27 27 3:04 P.22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 22F. HOW DID INJURY OCCUR?  
Struck by car while pushing Honda cycle

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner Deputy CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-28-71

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type) Werner U. Spitz, M.D.

M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial 12-30-71 Mountain View Cemetery

24C. NAME of CEMETERY or CREMATORIUM  
24D. LOCATION (City, town, or county) (State)  
Raleigh Co., W., Va.

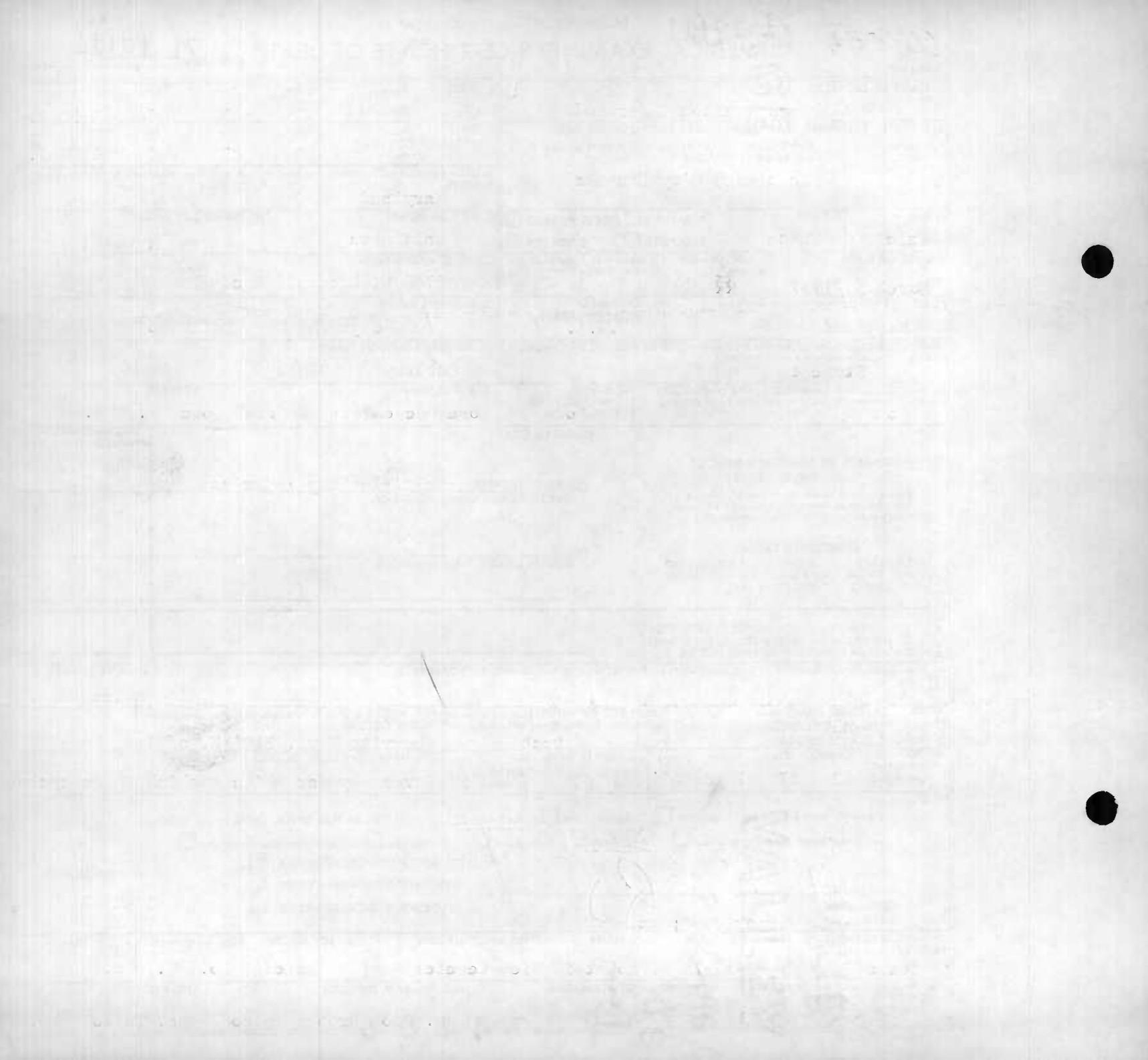
25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1972 Robert E. Johnson, M.D.

25B. NAME OF REGISTRAR  
25C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Towson, Inc. Towson, Md.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			REG. NO. <u>71 12112</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <u>12/27/71</u> 19:00 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CITY BALTO 5300</u>				
5. FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u>		C. CITY OR TOWN <u>CITY</u> D. INSIDE CITY LIMITS? E. STREET AND NUMBER <u>2023 Russell Ave.</u>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>Female</u>	7. RACE <u>White</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <u>3/11/01</u>	10. AGE (in years lost birthday) <u>70</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>				
13. FATHER'S NAME <u>Louis Berg</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Vogel</u>				
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-5261</u>			17. INFORMANT <u>Helena Lawrence</u> ADDRESS <u>Old Annapolis Rd. Rt #4 Ellicott City, Maryland</u>	
18. <u>410:8</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(B) <u>Anterior-septal MI massive</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCPD &amp; xr diaphragm</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION <u>12/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No.</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> to <u>12/27</u> , 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.						
23A. SIGNATURE <u>George C. Sammons MD</u>		23B. DATE SIGNED <u>12/27/71</u>				
23C. PHYSICIAN'S NAME (Type) <u>George C. Sammons MD</u>		23D. ADDRESS <u>MOTT</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/30/71</u>			24C. NAME OF CEMETERY OR CREMATORIAL <u>Woodlawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>						
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, Jr. D.I.</u>			25C. FUNERAL DIRECTOR <u>Armanast Funeral Chapel, 4600 Liberty Hts.</u>	
					ADDRESS <u>Armanast Funeral Chapel, 4600 Liberty Hts.</u>	
VS 150-REV. 1/1/68						

1960-1961  
1961-1962

May

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-500		71 12113		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____		71 12113	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/28/71 18 <sup>00</sup> A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE MD.		B. COUNTY Baltimore					
THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/09/27		9. AGE (In years last birthday) 44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Computer Programmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME RANDOLPH HAYNIE		14. MOTHER'S MAIDEN NAME OLIVIA LEASH							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-22-4913		17. INFORMANT Edward Haynie - 5612 Stonington Avenue #7		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer metastatic to Brain + bone Breast Cancer		(B) DUE TO, OR AS A CONSEQUENCE OF:  (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 01/26/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer Breast (2)		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on 12/28 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Noble Hansen MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/28/71					
23C. PHYSICIAN'S NAME (Type) NOBLE M. HANSEN M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71		24C. NAME OF CEMETERY or CREMATORIAL Woodlawn Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Sabey, M.P., C.R.		25C. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hts		ADDRESS			
VS 150-REV. 1/1/68									

15/8/81

INITIAL

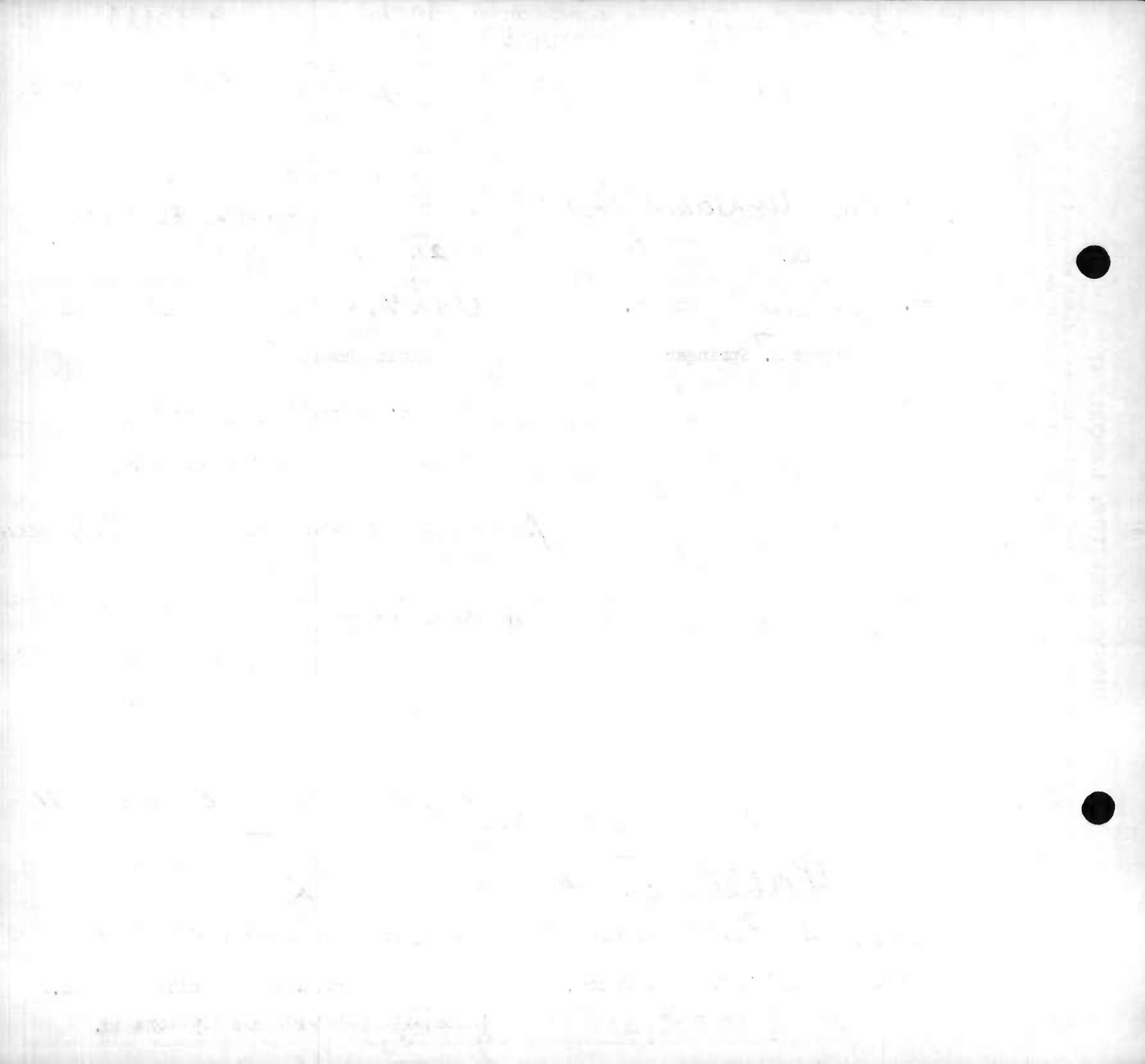
series

16

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

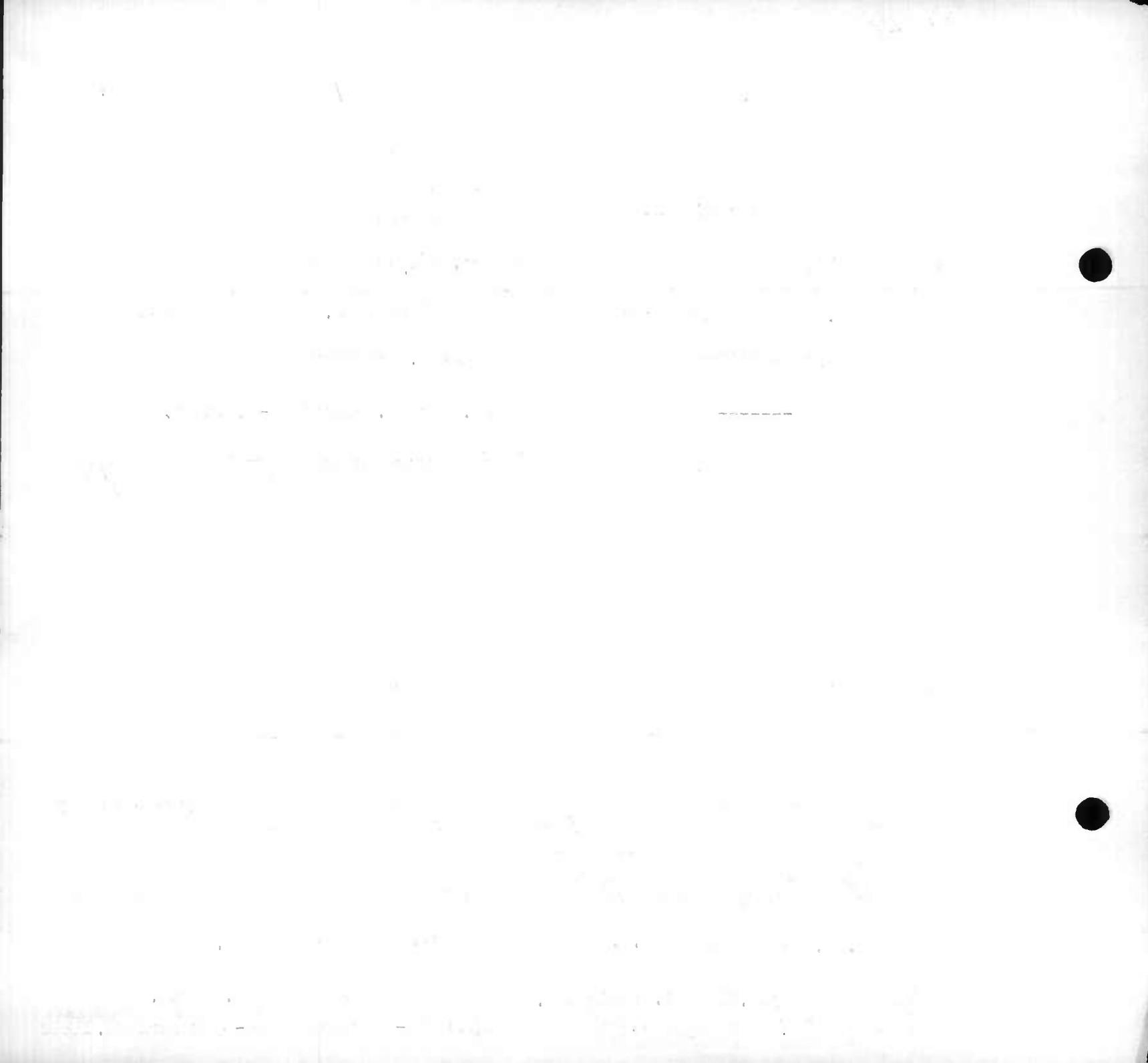
S-165		71 12114		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12114	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		SPRINGER, GEORGE E.		2. DATE AND HOUR OF DEATH 12-23-1971 11.20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>44</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2712</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect. <i>Retired.</i>		10B. KIND OF BUSINESS OR INDUSTRY Bus Co.		9. AGE (In years (lost birthday) <i>82?</i>		If Under 1 Yrs. Months: Days	
13. FATHER'S NAME <i>Eugene R. Springer</i>		14. MOTHER'S MAIDEN NAME <i>Elvia Thomas</i>		11. BIRTHPLACE (State or foreign country) <i>MARYland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT George L. Springer		ADDRESS Same	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Hyocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic Cardio V. Disease</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>Anemia</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-15 1971</i> to <i>12-23 1971</i> that (I) (we) last saw the deceased alive on <i>12-23 1971</i> and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Gattilano</i>		23B. DEGREE <i>MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) <i>Gattilano A. Battilana MD</i>	
23D. ADDRESS <i>UNION MEMORIAL HOSPITAL MD.</i>							
24A. BURIAL/CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY or CREMATORIUM Baltimore,		24D. LOCATION (City, town, or county) North Ave	
						(State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR <i>Robert E. Gabay, M.D.</i>		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		ADDRESS 6500 York Rd.	



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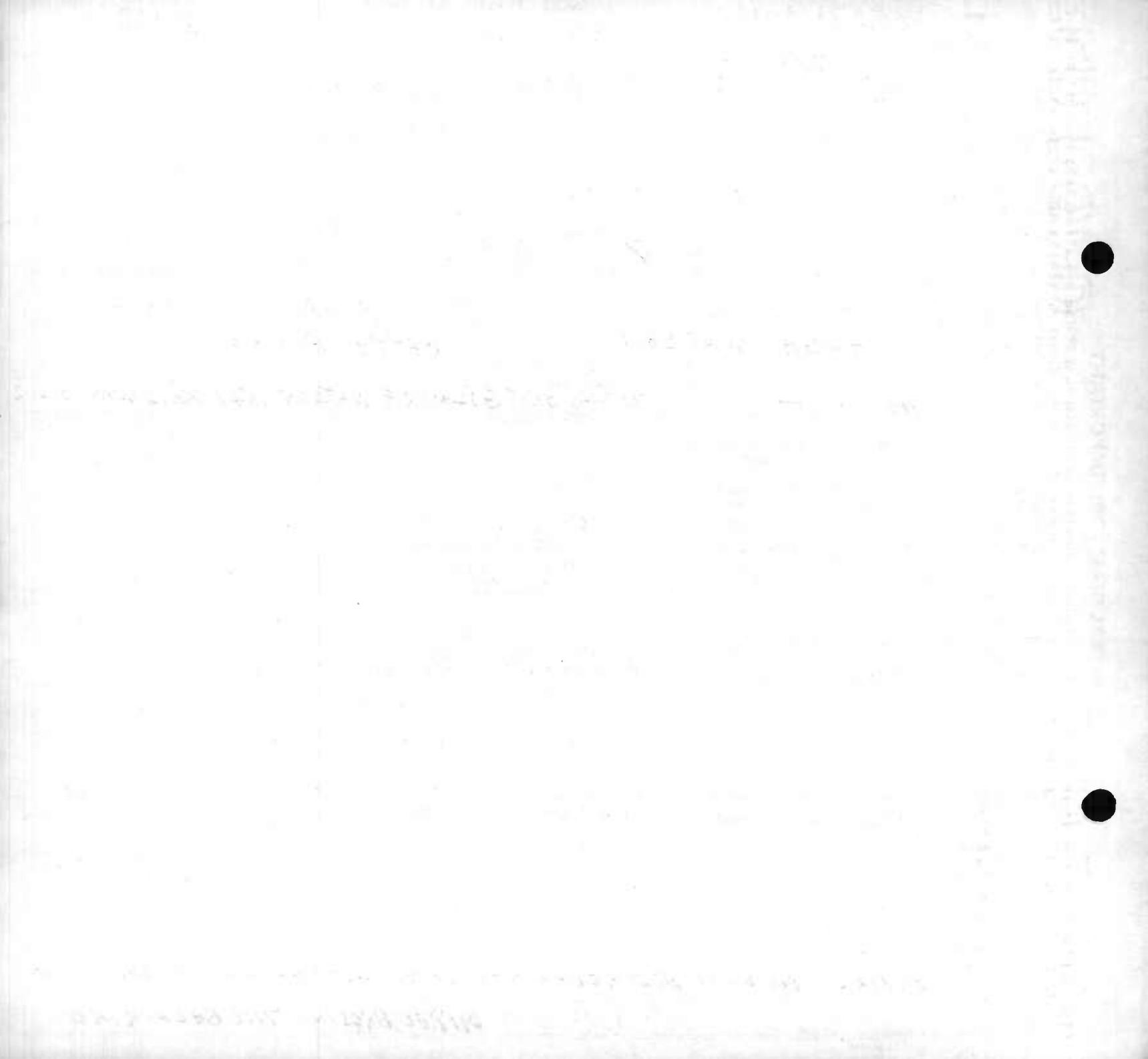
C-462		71 12115		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12115	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		EDNA G. CLARK		2. DATE AND HOUR OF DEATH		12/27/71		9:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland		B. COUNTY 2738	
FULL NAME OF HOSPITAL OR INSTITUTION		1310 Cedarcroft Road		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10A. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1920		9. AGE (in years last birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal Sec'y.		10B. KIND OF BUSINESS OR INDUSTRY Law Firm		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Albert Schneider		14. MOTHER'S MAIDEN NAME Anna M. Hemmeter		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna M. Schneider- (Mother)	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Carcinoma of Breast		19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
MEDICAL CERTIFICATION		19A. DATE OF OPERATION Jan '69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Breast		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (his hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on Dec. 17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jos. F. Palmisano M.D.		DEGREE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-28-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6608 Loch Raven Blvd.							
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/71		24C. NAME of CEMETERY or CREMATOR Y St. Pauls Cem.		24D. LOCATION (City, town, or county) Druid Hill Pk. Balto.		(State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Jaeger, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home-6500 York Rd. 21212		ADDRESS			



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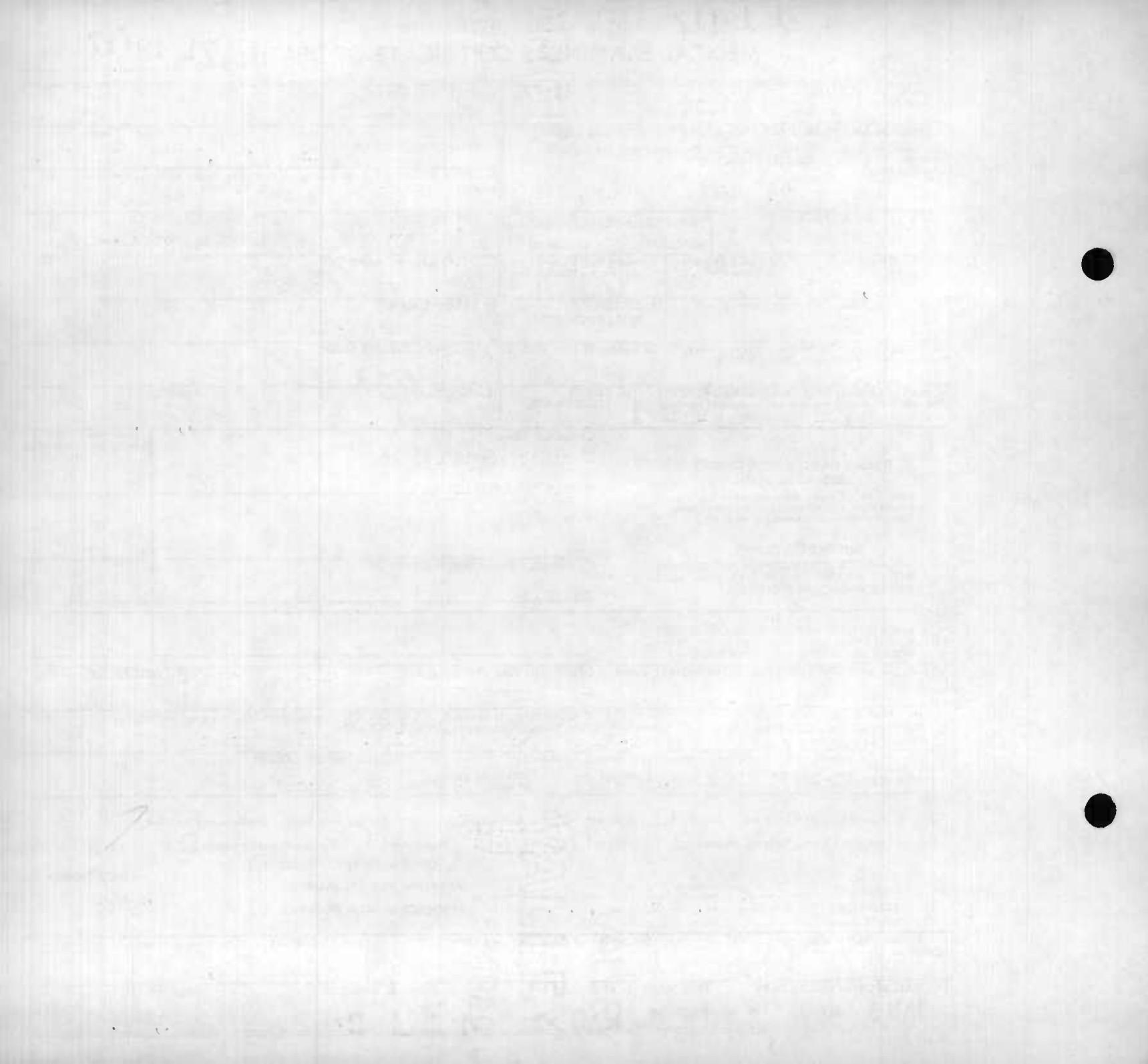
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12116	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/26/71 110 <sup>00</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 401			
FULL NAME OF HOSPITAL OR INSTITUTION  37 MERCY HOSPITAL 301 ST PAUL PLACE		C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1201-2 CHARLES CENTER		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/04	9. AGE (in years less birthday) 67	10. Under 1 Yr. Months Days Hours 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HUGH WATSON		14. MOTHER'S MAIDEN NAME BETTY BURKE		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-46-0295		17. INFORMANT ADDRESS GILMORE WATSON 1541 KING WAY 51212	
18. 397.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/4 muis	
(A) IMMEDIATE CAUSE Cancer respiration DUE TO, OR AS A CONSEQUENCE OF:		(B) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF:		(C) Pneumative Valvular Disease ?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Embolism (recurrent) Peripheral Vascular Disease		15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. DATE OF OPERATION 1/12/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastroenteric Hemorrhage		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/27 1971 to 12/16 1971 that (I) (we) last saw the deceased alive on 12/26 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fernando S. Remo, M.D.		23B. DATE SIGNED 12/16/71			
23C. PHYSICIAN'S NAME (Type) F. S. REMO		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 29-71		24C. NAME of CEMETERY or CREMATORIAL HOLY REDEEMER CEM.	
24D. LOCATION (City, town, or county) BELAIR RD BALTO MD		25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR DR. PRELBRAS INC 710 BELAIR RD	
25C. FUNERAL DIRECTOR ADDRESS		25D. LOCATION (City, town, or county) BELAIR RD BALTO MD			



1 W-325 71 12117 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 12117 REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELMER WATKINS			2. DATE Known <input type="checkbox"/> Month _____ Day _____ Year _____ Hour _____ OF DEATH Estimated <input type="checkbox"/>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____ M.
SOUTH BALTO. GENERAL HOSPITAL (DOA)			5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland 230-3 B. COUNTY
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH March 5, 1925		10. AGE (In years lost birthday) 46	If Under 1 Yr. II Under 24 Hrs. Months : Days : Hours : Min.
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF USA	E. STREET AND NUMBER 4 E. Barney Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		14B. KIND OF BUSINESS OR INDUSTRY Own Business	15. MOTHER'S MAIDEN NAME Calidonia Bentley
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes 1-19-46 to 8-29-46		17. SOCIAL SECURITY NO. 276 22 1404	18. INFORMANT Dolores D. Watkins ADDRESS 4 East Barney Street Balto., Md. 21230
19. E 955 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Gunshot wound of head APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
II 20. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21. AUTOPSY? (Yes or No) yes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg, etc.) Bar-Phone Booth	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 8 37 S. Charles Street 2201
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 12-28-71 10:25 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Self-inflicted
<p>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 12/29/71</p>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	24C. NAME OF CEMETERY or CREMATOR Y Glen Haven Memorial Park
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
25C. FUNERAL DIRECTOR McAdoo Funeral Home		ADDRESS 130 East Fort Avenue Balto., Md. 21230	



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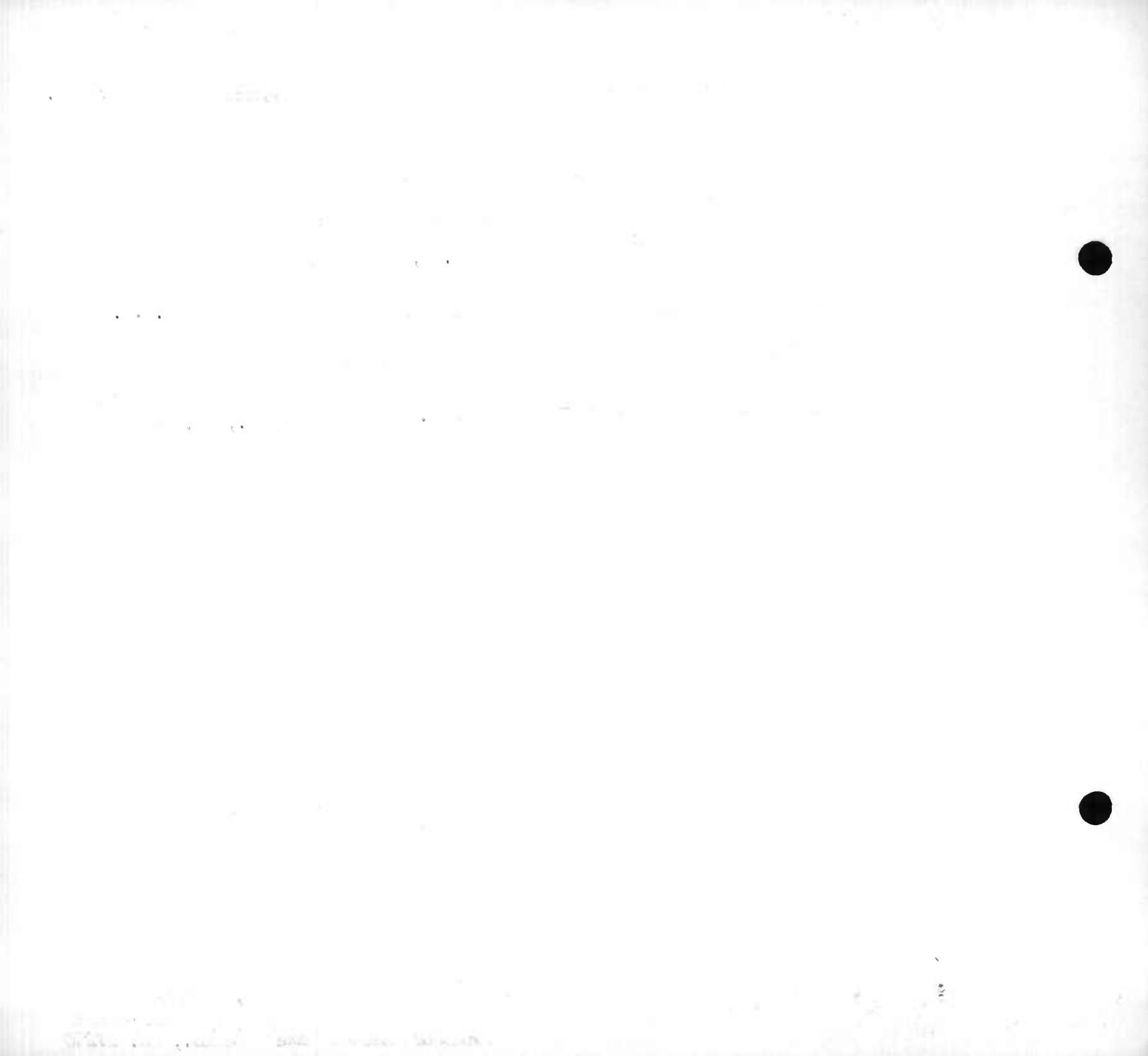
B-624 71 12118		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12118	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-29-71		505 5 PM	
1. NAME OF DECEASED (Type or Print) <u>Edith E. Bragel</u>		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>21239</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>Md. Gen. Hosp Balto. Md.</u>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3-31-04</u>		9. AGE (in years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>	
10A. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbur T. Hartley</u>		14. MOTHER'S MAIDEN NAME <u>Emily J. Penn</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-62-6505</u>		17. INFORMANT <u>Wosp. Chart</u>		18. CAUSE OF DEATH  <u>① Metastatic Oat Cell Car-Bronchogenic Cancer</u>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>		21. ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		23. MEDICAL CERTIFICATION 21A. DATE OF OPERATION <u>12-29-71</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>	
21C. AUTOPSY? (Yes or No) <u>No</u>		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21E. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21F. WHERE DID INJURY OCCUR? <u>-</u>		21G. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12-29 1971</u>		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>11-27 1971</u> to <u>12-29 1971</u> that (I) <u>we</u> last saw the deceased alive on <u>12-29 1971</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>(did not)</u> view the body after death.		23. SIGNATURE <u>Arnold G. Alexander MD</u>		23B. DATE SIGNED <u>12-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u>		23D. DEGREE <u>MD</u>		23E. ADDRESS <u>827 Linden Ave Batt. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/71</u>		24C. NAME OF CEMETERY OR CREMATORIAL <u>Friends Burial Ground</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor RA</u>	
25C. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>		ADDRESS <u>Seitz Funeral Home 5209 York Rd. Balto.</u>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

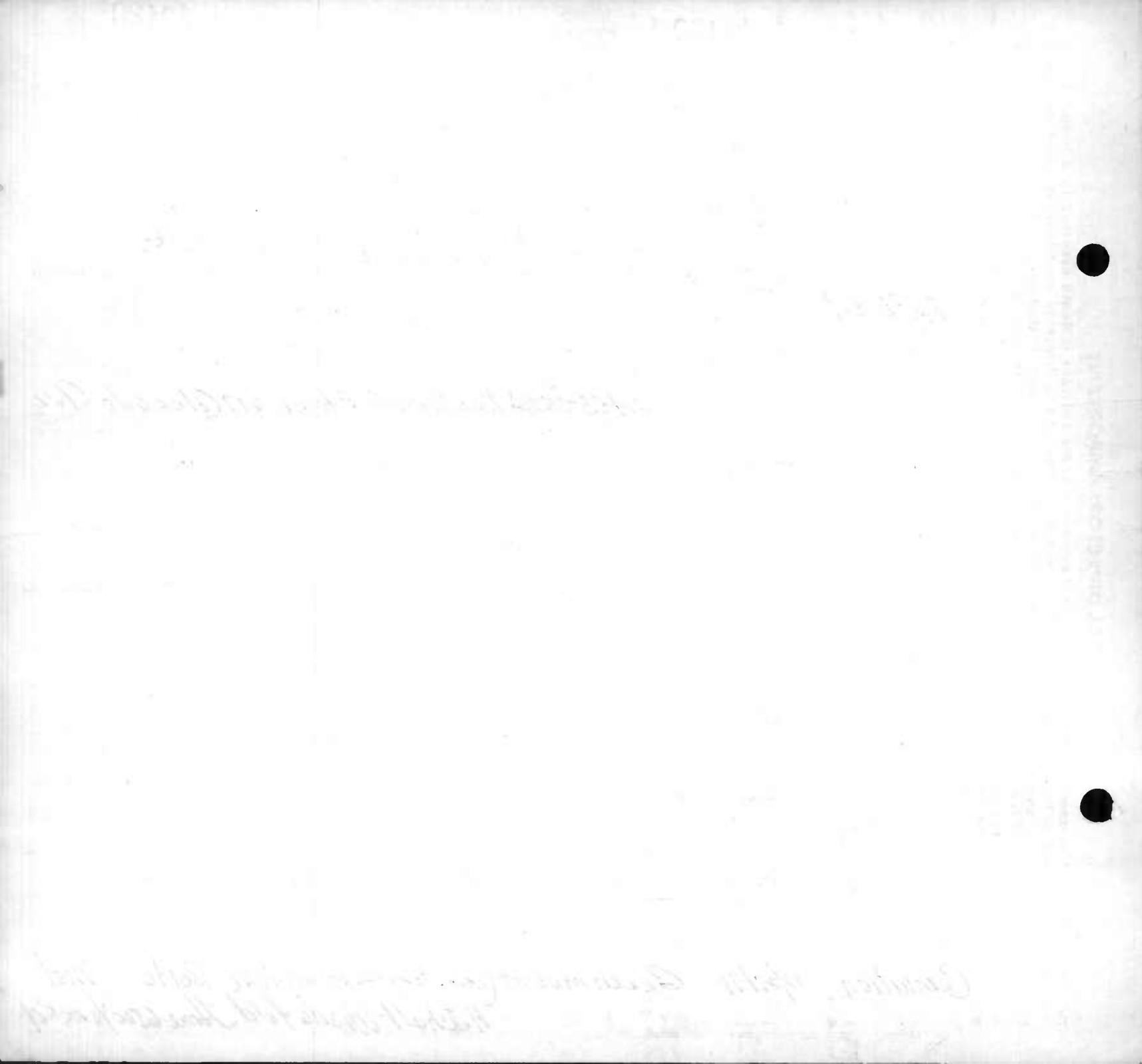
<span style="font-size: 2em; font-weight: bold;">N-635</span> <span style="font-size: 1.5em; font-weight: bold;">71 12119</span>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.2em; font-weight: bold;">71 12119</span>
1. NAME OF DECEASED <small>(Type or Print)</small>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em; font-weight: bold;">December 27, 1971 10:35 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <small>FULL NAME OF HOSPITAL OR INSTITUTION</small> <span style="font-size: 1.2em; font-weight: bold;">Harbor View Nursing Home</span> <span style="font-size: 1.2em; font-weight: bold;">1213 Light Street</span> <span style="font-size: 1.2em; font-weight: bold;">90</span>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) <small>A. STATE &amp; COUNTY</small> <span style="font-size: 1.2em; font-weight: bold;">Maryland</span> <span style="font-size: 1.2em; font-weight: bold;">Baltimore</span>		5. INSIDE CITY LIMITS? <small>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></small>
6. SEX <span style="font-size: 1.2em; font-weight: bold;">Male</span>		6. RACE <span style="font-size: 1.2em; font-weight: bold;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em; font-weight: bold;">Ship yard worker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em; font-weight: bold;">-----</span>		8. DATE OF BIRTH <span style="font-size: 1.2em; font-weight: bold;">Feb. 22, 1893</span>
13. FATHER'S NAME <span style="font-size: 1.2em; font-weight: bold;">Thomas Norton</span>		9. AGE (in years lost birthday) <span style="font-size: 1.2em; font-weight: bold;">78</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em; font-weight: bold;">Maryland</span>
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) If yes, give war or dates of service</small> <span style="font-size: 1.2em; font-weight: bold;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em; font-weight: bold;">215-01-3221</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em; font-weight: bold;">U.S.A.</span>
18. <span style="font-size: 1.2em; font-weight: bold;">412.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small>		19. CAUSE OF DEATH <span style="font-size: 1.2em; font-weight: bold;">-----</span>		ADDRESS <span style="font-size: 1.2em; font-weight: bold;">1120 Battery Avenue</span> <span style="font-size: 1.2em; font-weight: bold;">Balto., Md. 21230</span>
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em; font-weight: bold;">Weeks</span>				
21. ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</small>		(A) IMMEDIATE CAUSE <span style="font-size: 1.2em; font-weight: bold;">Cerebral Ischemia</span> <small>DUE TO, OR AS A CONSEQUENCE OF:</small>		
		(B) <span style="font-size: 1.2em; font-weight: bold;">Advanced ASCVD</span> <small>DUE TO, OR AS A CONSEQUENCE OF:</small>		<span style="font-size: 1.2em; font-weight: bold;">Years</span>
		(C) <span style="font-size: 1.2em; font-weight: bold;">Anemia</span>		<span style="font-size: 1.2em; font-weight: bold;">Years</span>
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em; font-weight: bold;">-----</span>				
23. MEDICAL CERTIFICATION <span style="font-size: 1.2em; font-weight: bold;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em; font-weight: bold;">-----</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em; font-weight: bold;">-----</span>
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <small>(If in Baltimore City, give exact location)</small>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>
21D. TIME (Month) (Day) (Year) (Hour) <small>(APPROX.)</small>		21E. INJURY OCCURRED <small>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></small>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em; font-weight: bold;">December 16, 1971</span> to <span style="font-size: 1.2em; font-weight: bold;">December 27, 1971</span> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <span style="font-size: 1.2em; font-weight: bold;">December 27, 1971</span> and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em; font-weight: bold;">Peter H. Rheinstein, MD</span>		DEGREE <small>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></small>		23B. DATE SIGNED <span style="font-size: 1.2em; font-weight: bold;">Dec 28, 1971</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em; font-weight: bold;">PETER H. RHEINSTEIN, MD</span>		23D. ADDRESS <span style="font-size: 1.2em; font-weight: bold;">HARBOR VIEW NURSING HOME</span>		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <span style="font-size: 1.2em; font-weight: bold;">Burial</span>		24C. NAME OF CEMETERY OR CREMATORIAL <span style="font-size: 1.2em; font-weight: bold;">Glen Haven Memorial Gardens</span>		24D. LOCATION (City, town, or county) <span style="font-size: 1.2em; font-weight: bold;">Glen Burnie, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em; font-weight: bold;">JAN 3 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em; font-weight: bold;">R. E. J. 2007</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em; font-weight: bold;">M. Fully Funeral Home</span>
				ADDRESS <span style="font-size: 1.2em; font-weight: bold;">130 East Fort Avenue</span> <span style="font-size: 1.2em; font-weight: bold;">Balto., Md. 21230</span>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460		71 12120	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	REG. NO. 71 12120
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12-22-71 8 <sup>10</sup> P.M.			
GARNETT R. MILLER					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE CITY of Baltimore 2713 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 04-24-95		9. AGE (In years lost birthday) 76		11. Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
13. FATHER'S NAME THOMPSON J. MILLER		14. MOTHER'S MAIDEN NAME ANNIE O'NEAL		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 21403-0559A		17. INFORMANT Miss Ann O. Blome -617 Colorado Ave	
18. 412.41 CAUSE OF DEATH				ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF: <b></b>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-22-71 19 to 12-22-71 19 that (I) (we) last saw the deceased alive on 12-22-71 19 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		MD DEGREE		23B. DATE SIGNED 12-22-71	
23C. PHYSICIAN'S NAME (Type) <b>JAIRO RAMIREZ</b>		23D. ADDRESS ND UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE 12/27/71		24C. NAME OF CEMETERY or CREMATORIAL Greenmount Cemetery Greenmount Ave Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert S. Johnson		25C. FUNERAL DIRECTOR Michael Woodsold Home 6500 York Rd ADDRESS	



S-165

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12121

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

P-1. William Severin

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(If not in hospital or institution, give street  
address or location)

972 North Hill Road

## 6. SEX

male

## 7. RACE

White

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 9. DATE OF BIRTH

10. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

USA

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHIEF ENGINEER

## 14B. KIND OF BUSINESS OR INDUSTRY

TOWING Co.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

215-09-8964

## 15. MOTHER'S MAIDEN NAME

ERNESTINE (?)

## 18. INFORMANT

MRS. MARGARET F. SEVERIN SAME

## ADDRESS

## 19. 412.41

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/25/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

## 24B. DATE

12/28/71

## 24C. NAME OF CEMETERY or CREMATORI

NEW CATHEDRAL CEM.

## 24D. LOCATION (City, town, or county)

BALTIMORE,

## (State)

MD.

## 25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1972

## 25B. NAME OF REGISTRAR

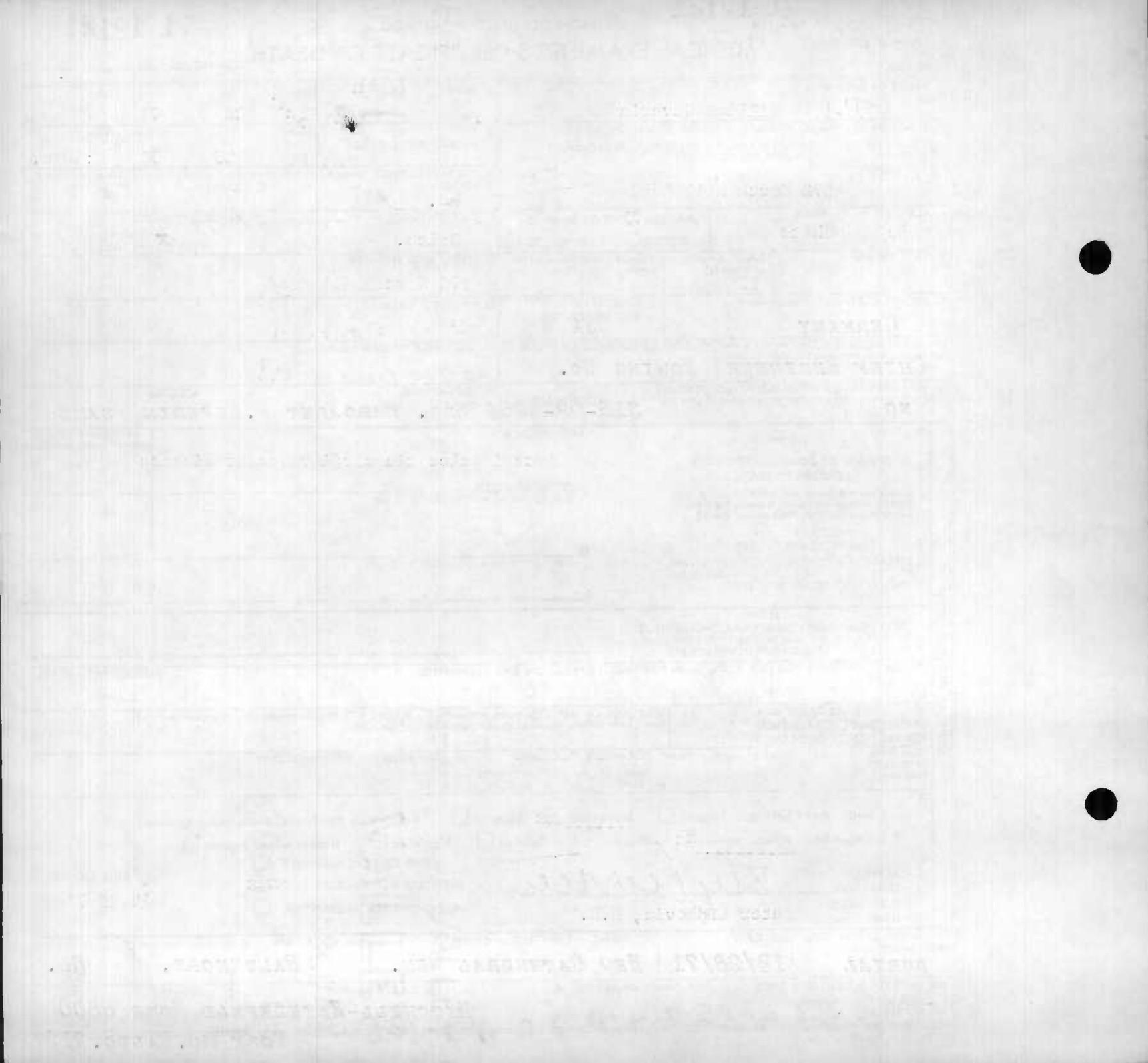
Robert E. Faber, M.D.

## 25C. FUNERAL DIRECTOR

MITCHELL-KWIEDEFELD HOME 6500

## ADDRESS

YORK RD. BALTO. 21212



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

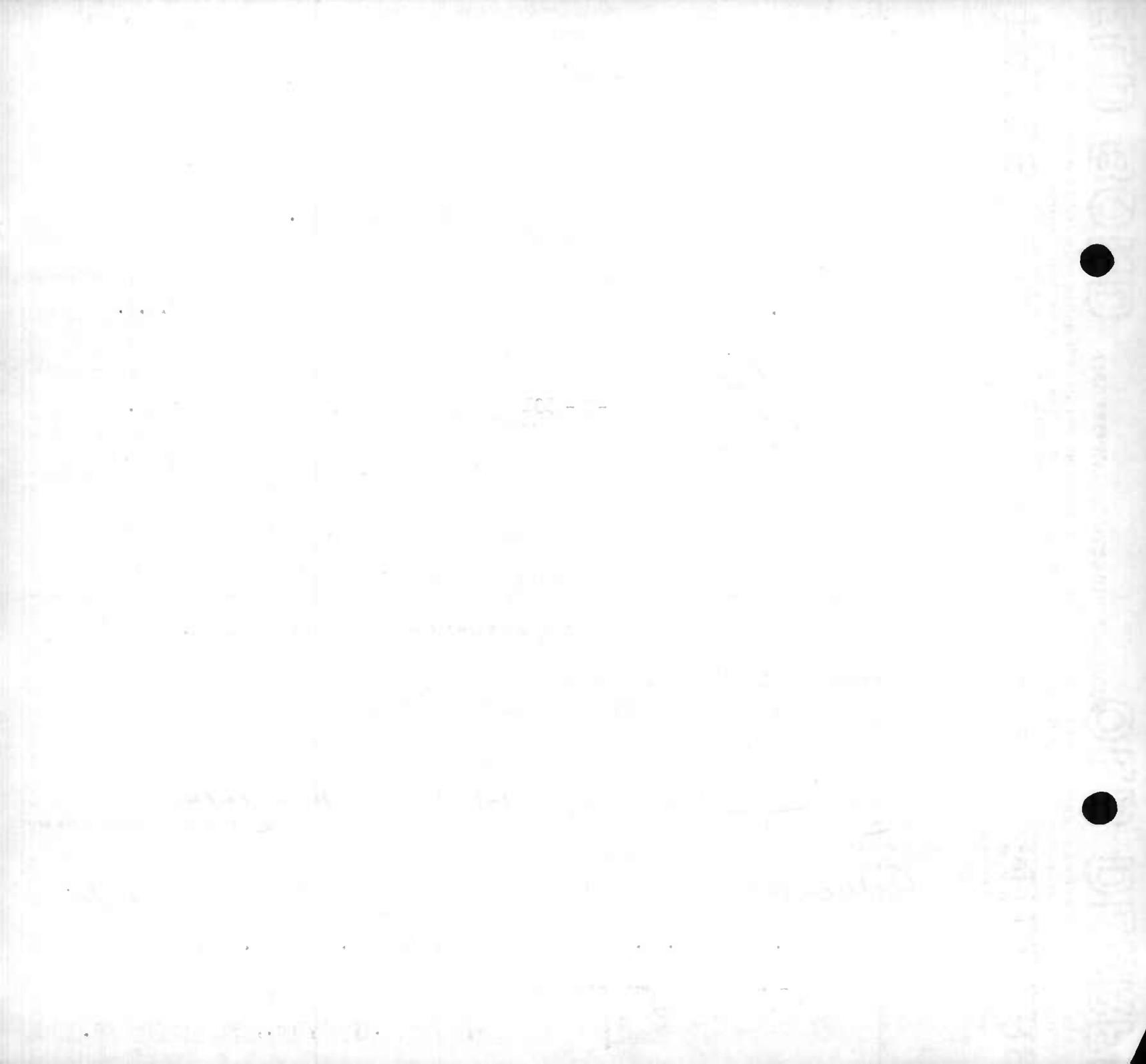
H-416 BIRTH NO.		71 12122	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12122			
1. NAME OF DECEASED (Type or Print)		HALBERT, NORMA V		2. DATE AND HOUR OF DEATH DEC 24, 1971 11:15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE 2303						
42 SINAI HOSPITAL BALTIMORE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX F		6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6 1904	9. AGE (in years last birthday) 67	10. KIND OF BUSINESS OR INDUSTRY Hopkins Hospital	11. BIRTHPLACE (State or foreign country) Balto Md.	12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. SOCIAL SECURITY NO. 214 036030		13. FATHER'S NAME Charles Tornallan		14. MOTHER'S MAIDEN NAME Florence Jony		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. ADDRESS LaVern Hampton 105 Condon Ave Glen Burnie Md						
18. 571.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  HEPATIC COMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ADVANCE POST - HEPATITIC CIRRHOsis DUE TO, OR AS A CONSEQUENCE OF:						
(C).....								
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								
20. MEDICAL CERTIFICATION DATE OF OPERATION 21. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from DEC. 2 1971 to DEC. 27 1971 that (I) (we) last saw the deceased alive on DEC. 27 1971 and that In (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE Armando C. DiNAMCO, M.D.		23B. DATE SIGNED Dec. 27, 1971						
23C. PHYSICIAN'S NAME (Type) ARMANDO C. DINAMCO, M.D.		23D. ADDRESS SINAI HOSP. BALTIMORE, MD.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) 2930 Frederick Ave		
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Ruth E. Jackson		25C. FUNERAL DIRECTOR Maurice Funeral Home		ADDRESS 237 Patapsco Ave 21225		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Determined cause was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-625 71 12123		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12123							
BIRTH NO.											
1. NAME OF DECEASED (Type or Print)		ANNE MARY AGNES <i>MORGAN</i>		2. DATE AND HOUR OF DEATH <i>12/30/71</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <i>37 MERCY HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MARYLAND</i>		4.20 P.M. <i>2633</i>							
FULL NAME OF HOSPITAL OR INSTITUTION		B. CITY OR TOWN <i>BALTIMORE</i>		C. STREET AND NUMBER <i>3303 Ramona Ave.</i>							
5. SEX <i>F</i>		6. RACE <i>W</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary Ret.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>							
13. FATHER'S NAME <i>James Francis Morgan</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Caffrey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-05-1331</i>		17. INFORMANT <i>Madeline Klein, 5715 Benton Hghts.</i>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cardio respiratory arrest</i>		15 mins							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>		23 days							
(C) DUE TO, OR AS A CONSEQUENCE OF: <i>congestive heart failure</i>		(D) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular disease</i>		6 mos							
MEDICAL CERTIFICATION		20A. DATE OF OPERATION <i>12/28/71</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>removal of specimen</i>		20C. AUTOPSY? (Yes or No) <i>No</i>		20D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING? <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/27/71</i> to <i>12/30/71</i> that (I) (we) last saw the deceased alive on <i>12/30/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Eduardo S. Remo MD</i>		23B. DATE SIGNED <i>12/30/71</i>									
23C. PHYSICIAN'S NAME (Type) <i>EDUARDO S. REMO, M.D.</i>		23D. ADDRESS <i>MERCY HOSPITAL 301 St. Paul Pl.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-3-72</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral</i>		24D. LOCATION <i>Baltimore, Maryland</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Parker, Jr.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Puck, Inc., 5305 Harford Rd.</i>		ADDRESS					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12124		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12124	
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH				2. DATE AND HOUR OF DEATH	
<b>Mary Elizabeth Payne</b>						12/28/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2731	
FULL NAME OF HOSPITAL OR INSTITUTION <i>OO</i>		(If not in hospital or institution, give street address or location)				C. CITY OR TOWN Balto.	
3905 Parkside Drive						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/29/89	9. AGE (in years lost birthday) 82	II Under 1 Yr. Months: Days	II Under 24 Hrs. Hours	III Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John</b> <i>H. Kirchner</i>		14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-54-6584</b>		17. INFORMANT <b>John Payne (son)</b>		ADDRESS <b>same as above</b>	
18. <b>410-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.							
<p style="text-align: center;">CAUSE OF DEATH</p> <p><i>Pulmonary Thrombosis</i></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><i>Arteriosclerotic C-V Disease</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> <p style="text-align: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>							
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <b>O</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>11/28/71</b> to <b>12/30/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>L.B. Stevens MD</i>		23B. DEGREE Attending Phys. <input checked="" type="checkbox"/>		Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. DATE SIGNED <b>12/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. L. B. Stevens</b>		23D. ADDRESS <b>3400 Erdman Ave.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY or CREMATORIALy <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) <b>Balto. Md.</b> (State) <b>MD</b>	
25A. DATE REGD BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>	

1940-1941

1940-1941

1940-1941

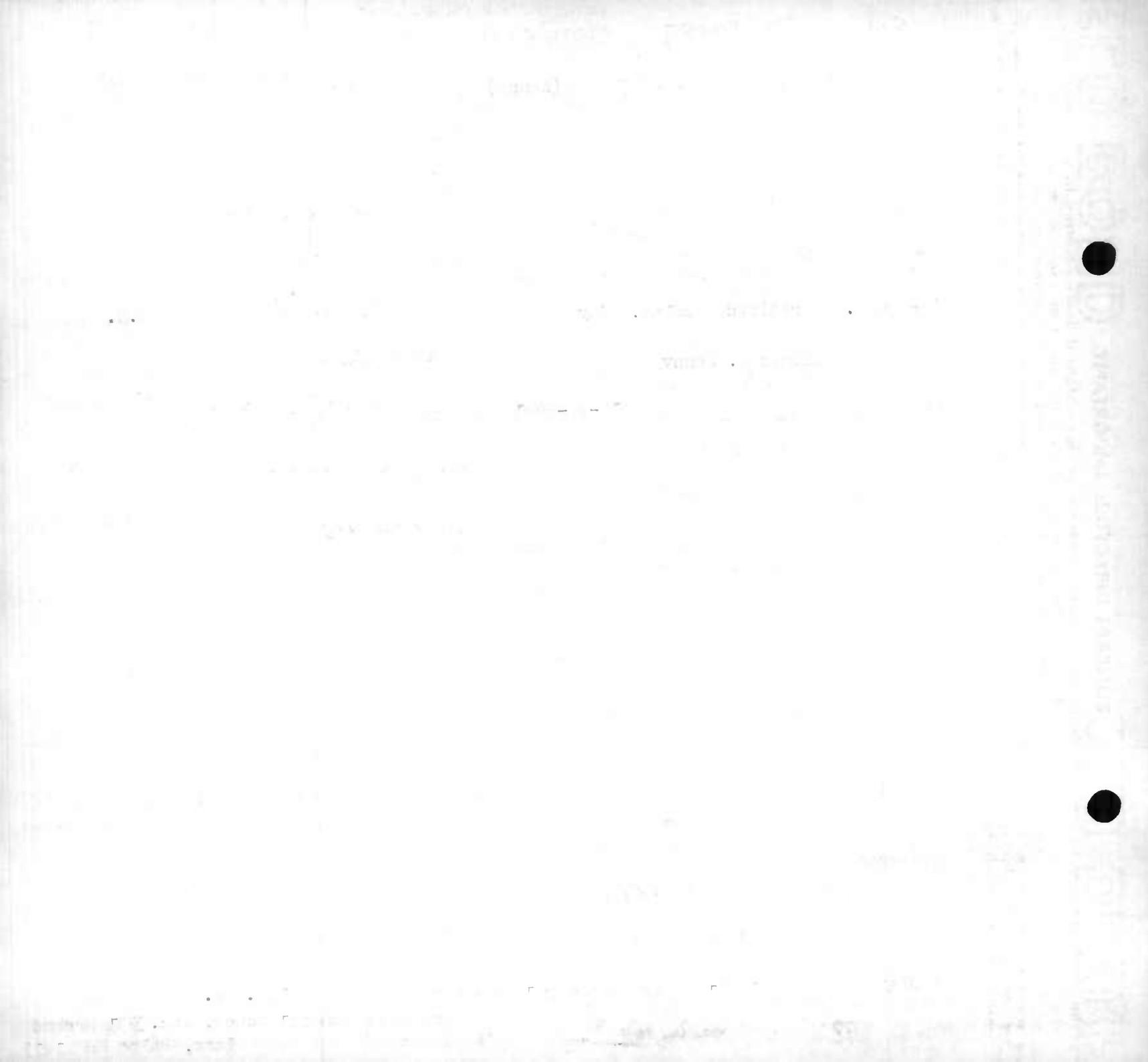
1940-1941

1940-1941

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

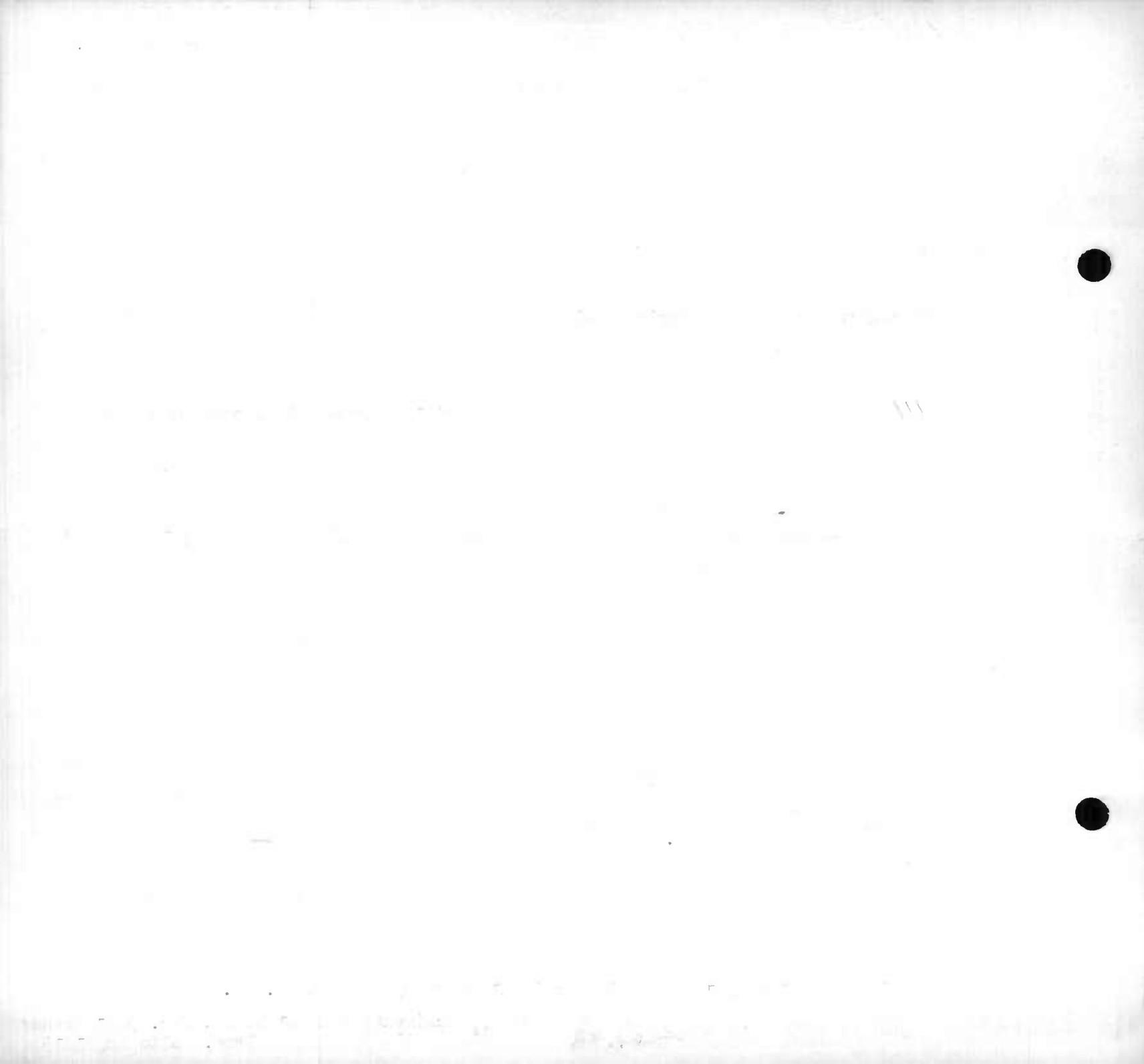
Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 71 12125
K-500 BIRTH NO.		71 12125		
1. NAME OF DECEASED (Type or Print)		(Kenny)		2. DATE AND HOUR OF DEATH DEC 27 1971 8:15 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  44 UNION MEMORIAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE BALT B. COUNTY BALT
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN BALT D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE W		E. STREET AND NUMBER 3107 MARCO RD
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-22-01		9. AGE (In years lost birthday) 70 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Dept E.T. retired		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		13. FATHER'S NAME Thomas J. Kenny 14. MOTHER'S MAIDEN NAME Annie Diggs
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-28-9621		17. INFORMANT WIFE EFFIE L. KENNY SDW ADDRESS
18. 49XX I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Black PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 4 YRS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) X		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-27 1971 to 12-27 1971 that (I) (we) last saw the deceased alive on 12-27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Francis X. CIRMOY		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-27-71
23C. PHYSICIAN'S NAME (Type) FRANCIS X. CIRMOY		23D. ADDRESS 3201 N CHARLES		
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/30/71		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE New Cathedral Cemetery
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Schimmele, Inc.		25C. FUNERAL DIRECTOR Schimmele Funeral Homes, Inc. 3331 Brighms Lane, Baltimore MD 21213



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the physician by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

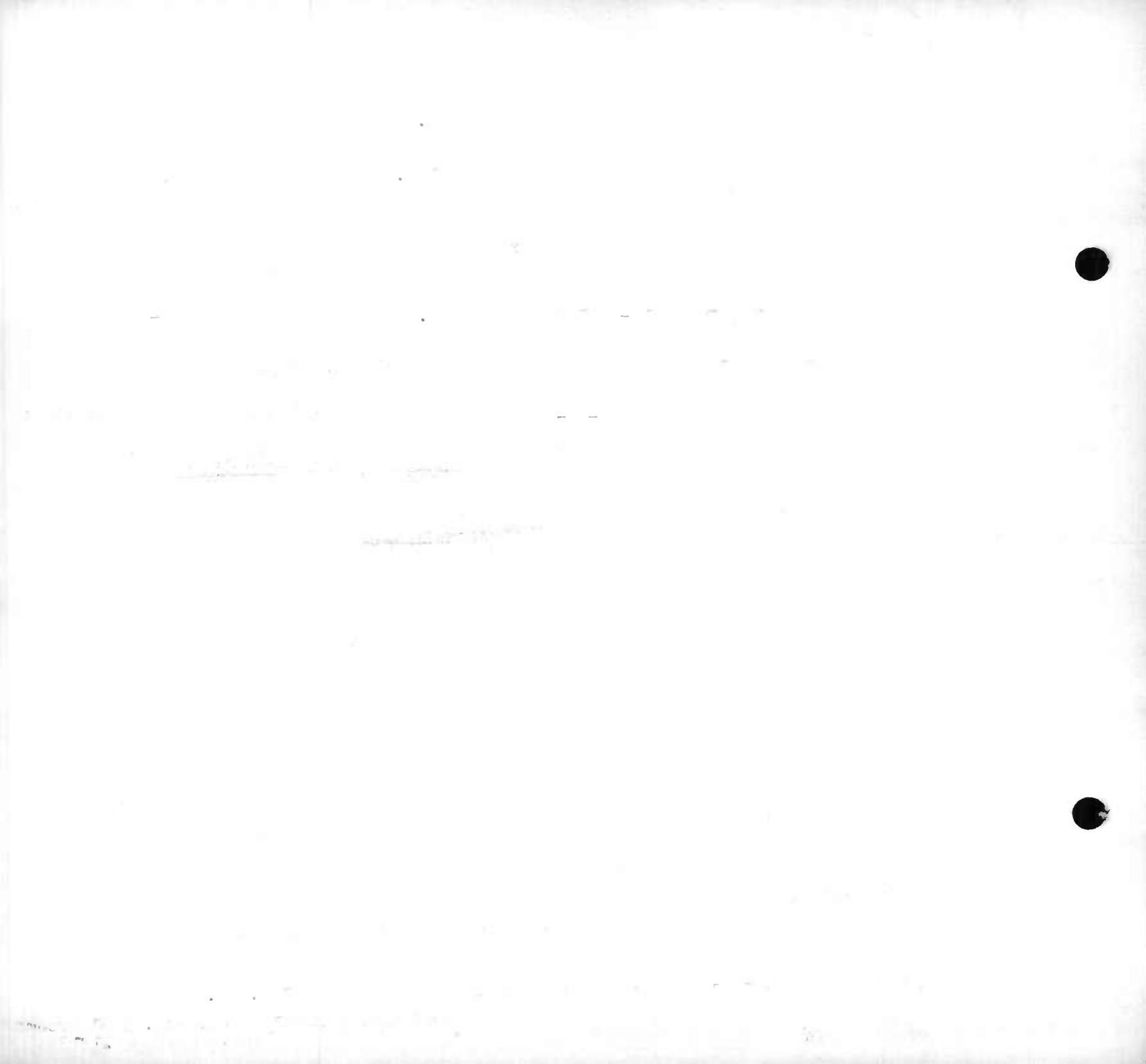
P-650		71 12128		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12128							
BIRTH NO.															
1. NAME OF DECEASED (Type or Print)		PERRON, THEODORE PHILIAS				2. DATE AND HOUR OF DEATH 12/27/71 4:30 A.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  49 North Charles General Hosp		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. SEX M 6. RACE W		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH 7-30-08 8. AGE (in years last birthday) 63		9. If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10B. KIND OF BUSINESS OR INDUSTRY Harris & Ewing		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME PHILIAS PERRON		14. MOTHER'S MAIDEN NAME EMMA FREMONT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 030-09-2238		17. INFORMANT Lucille Perron (wife) same as above		18. CAUSE OF DEATH 567.44250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
20. MEDICAL CERTIFICATION O		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. I certify that (I) (this hospital) attended the deceased from 12/23 1971 to 12/27 1971 that (I) (we) last saw the deceased alive on 12/27 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No)		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)			
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. TIME (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR?					
33. I certify that (I) (this hospital) attended the deceased from _____ to _____ and that (I) (we) last saw the deceased alive on _____ and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		34. SIGNATURE Rufino G. Montenegro M.D.		35. PHYSICIAN'S NAME (Type) RUFINO G. MONTEVERDE M.D.		36. DEGREE M.D.		37. ATTENDING PHYS. <input type="checkbox"/>		38. MED. DIRECTOR <input type="checkbox"/>		39. STAFF PHYS. <input checked="" type="checkbox"/>		40. DATE SIGNED 12/27/71	
41. BURIAL CREMATION, REMOVAL (Specify) BURIAL		42. DATE 12/30/71		43. NAME OF CEMETERY OR CREMATORIAL Bohemian National Cemetery		44. LOCATION Balto. Md.		45. CITY, TOWN, OR COUNTY (City, town, or county) Balto. Md.		(State)					
46. DATE REC'D BY HEALTH DEPT. JAN 3 1972		47. NAME OF REGISTRAR Robert E. Faber, Jr.		48. FUNERAL DIRECTOR Schimmeck Funeral Homes, Inc.		49. ADDRESS 3331 Brehms Lane, Balto. Md. 21213									



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

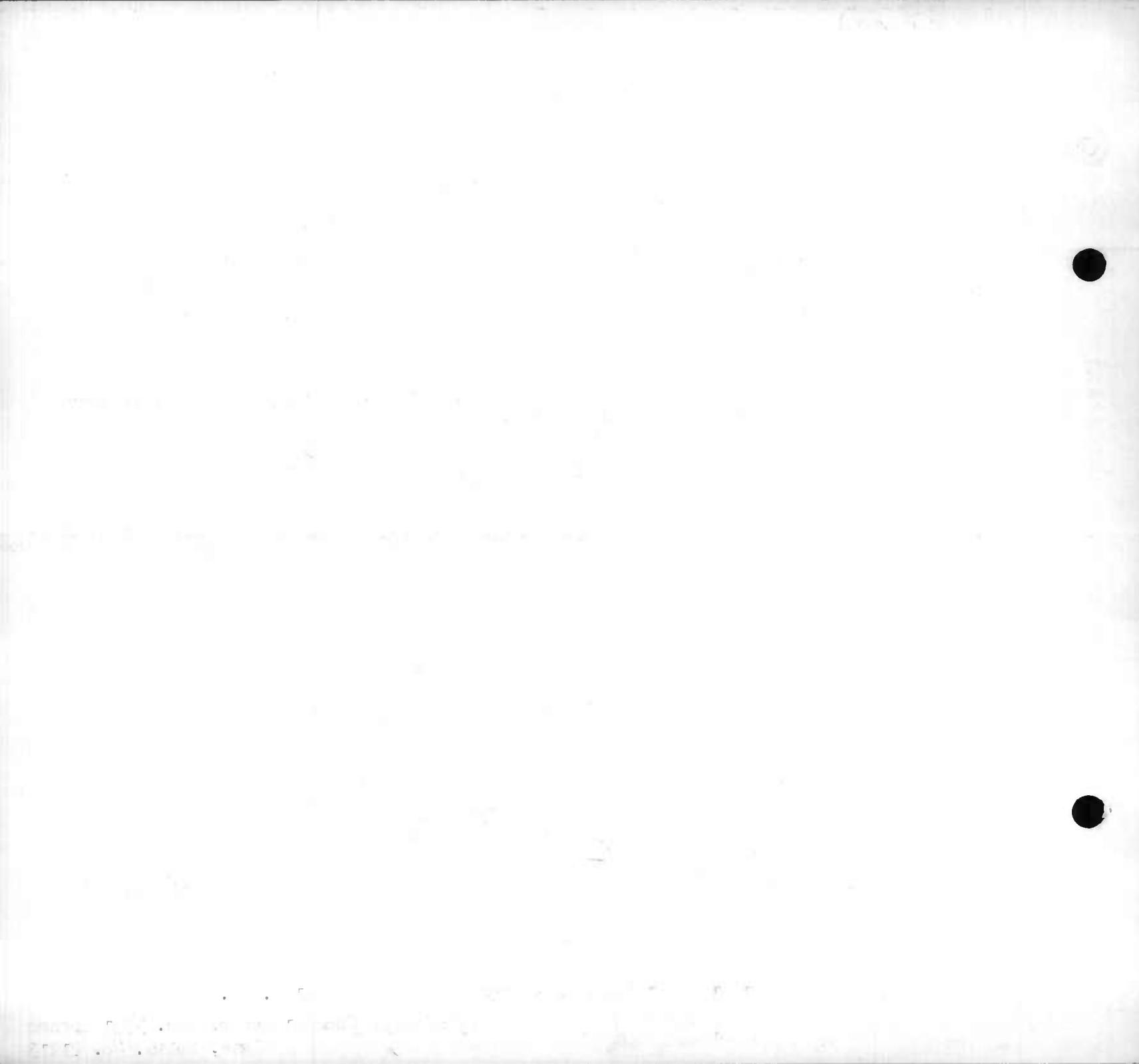
K-342		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12127
BIRTH NO.	71 12127		12. DATE AND HOUR OF DEATH DEC 28 1971, 12:30 P.M.	
1. NAME OF DECEASED (Type or Print) Anthony J KOTALIK		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		A. STATE Md. B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md. General Hosp 48		E. STREET AND NUMBER 1214 Eutaw Pl 3583 Shannon Drive		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-99	9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Vaclav Kotlik		14. MOTHER'S MAIDEN NAME Catherine Handreich		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-54-6996		17. INFORMANT Mary Conrad (sister)
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)		CAUSE OF DEATH Bronchopneumonia, bilateral		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 1		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
MEDICAL CERTIFICATION 20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? In Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Donald N. Hislop, MD		23B. DATE SIGNED 12/28/71		
23C. PHYSICIAN'S NAME (Type) DONALD N. HISLOP, MD		23D. ADDRESS R16H		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith Cemetery
24D. LOCATION (City, town, or county) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Farley, RD		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. ADDRESS 3331 Brehms Lane, Balto. Md. 21213
VS 150-REV. 1/1/68				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12128	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12128
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH			
CHARLES P COOK		2. DATE AND HOUR OF DEATH		12/27/71 10:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
NORTH CHARLES GENERAL HOSPITAL		A. STATE	B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
NORTH CHARLES GENERAL HOSPITAL		BALTIMORE		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
E. STREET AND NUMBER		2634			
4825 ORVILLE AVE					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. Months Days Hours Min.
MALE	WHITE		10-23-04	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
EMPLOYEE, B&O RR		RAILROAD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
UPTON COOK		MARGARET SPIDAL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES		214-09-6887		Jennie Cook (wife) PATIENT CHART	
18. CAUSE OF DEATH		ADDRESS same as above			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES		Bronchopneumia, Bell lung			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
II		Bronchogenic Ca with wide spread metastases			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/>		Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/12 1971 to 12/27 1971 that (I) (we) last saw the deceased alive on 12/27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Edward Sherrill MD				28 Dec 71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Edward Sherrill MD		N. Char. Gen Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORIAL	
BURIAL		12/31/71		Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 3 1972		Robert E. Tolson, Jr.		Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213	
ADDRESS					
VS 150-REV. 1/1/68					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		71 12129		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12129	
BIRTH NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		M. William H. Riley		2. DATE AND HOUR OF DEATH 12/28/71		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  CERTIFICATE AMENDED 00 3815 Belair Rd. 2-17-71				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2633			
5. SEX M 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/89		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor		10B. KIND OF BUSINESS OR INDUSTRY Penna. R. R.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME William T. Riley				14. MOTHER'S MAIDEN NAME Sarah Dailey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 717-07-8439		17. INFORMANT Anna Riley (wife)		ADDRESS same as above	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH McGraw's 20	
				(A) IMMEDIATE CAUSE Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Underlying C. V. Disease DUE TO, OR AS A CONSEQUENCE OF:			
				(C).....			
II MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harold H Burns		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 12-29-71	
23C. PHYSICIAN'S NAME (Type) Dr. Harold Burns		23D. ADDRESS 8106 Harford Rd.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/31/71		24C. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		24D. LOCATION (City, town, or county) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Dailey Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	

2-17-1972 - Notification from Harold H. Burns, M.D.  
8106 Harford Road - Balto., Md. HRS

71 12130

BALTIMORE CITY HEALTH DEPARTMENT

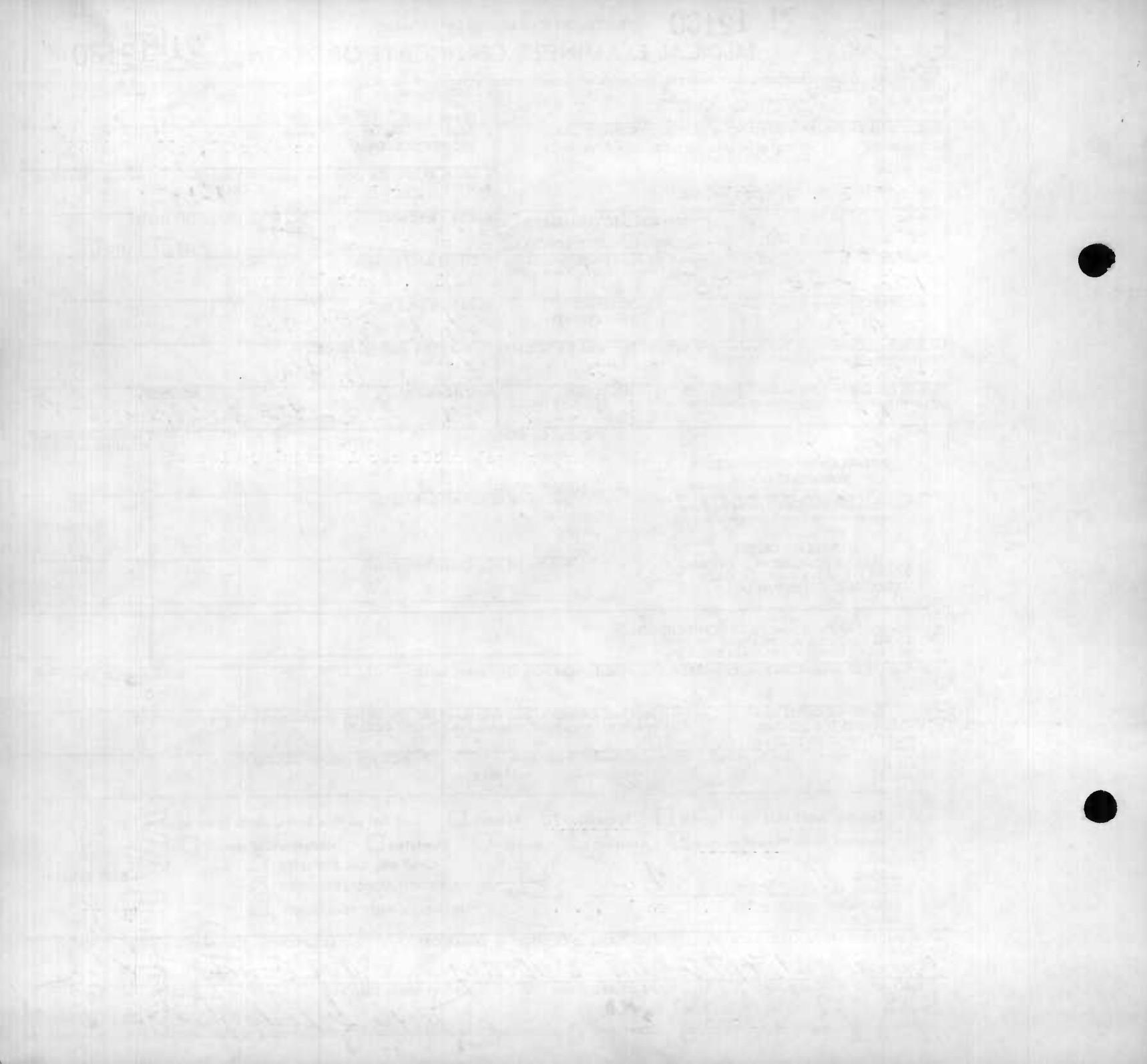
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12130

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		HERBERT JOHNSON		2. DATE OF DEATH	Known <input type="checkbox"/> Month _____	Day _____	Year _____	Hour _____
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  1403 N. Central Avenue				Estimated <input type="checkbox"/>				M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3. DATE PRONOUNCED DEAD	Month December	Day 31, 1971	Year 1971	Hour 1:45 A.M.
9. DATE OF BIRTH 1-28-96		10. AGE (In years last birthday) 75	If Under 1 Yr. <input type="checkbox"/> Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? J. H. Hosp.		E. STREET AND NUMBER 1403 N. Central Avenue				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		14B. KIND OF BUSINESS OR INDUSTRY J. H. Hosp.		15. MOTHER'S MAIDEN NAME Laura Anderson	16. INFORMANT Ethel Lockett 1403 N. Central Ave			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-14-7689	ADDRESS					
19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C) _____						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> and that on this basis, death in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72	24C. NAME OF CEMETERY or CREMATORIAL Mt. Calvary	DATE SIGNED 12/31/71				
25A. DATE REC'D BY HEALTH-DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Mabel E. Kornblum, M.D.		25C. FUNERAL DIRECTOR Joseph S. Lockett 1403 N. Central Ave				
VS 151-REV. 1/1/68				ADDRESS				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 BIRTH NO.		71 12131	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12131
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH		
LACY BOOTH		2. DATE AND HOUR OF DEATH 12-30-71 8.00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  THE UNION MEMORIAL HOSPITAL 44		4. USUAL RESIDENCE (Where deceased lived II Institutions residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE 1202		
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 8423 BARCLAY ST. 21218				
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-18	9. AGE (in years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONCRETE MAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MISSISSIPPI
13. FATHER'S NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT Robert Booth 2708 Murray St		ADDRESS		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  Hepatic failure. Portal Cirrhosis -  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Chronic Alcoholism.  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  Pneumonia.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION O	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No.	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Identify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-10 19 71 to 12-30 19 71 that (I) (we) last saw the deceased alive on 12-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Anne L. Leddy M.D.		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 12-30-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/4/72	24C. NAME of CEMETERY or CREMATORIAL Mt. Calvary	24D. LOCATION (City, town, or community) D.C. County, Md.	(State)
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972	25B. NAME OF REGISTRAR R. E. B. Wilson, M.D.	25C. FUNERAL DIRECTOR Joseph J. Walsh Jr.	ADDRESS 1304 N Central Ave	

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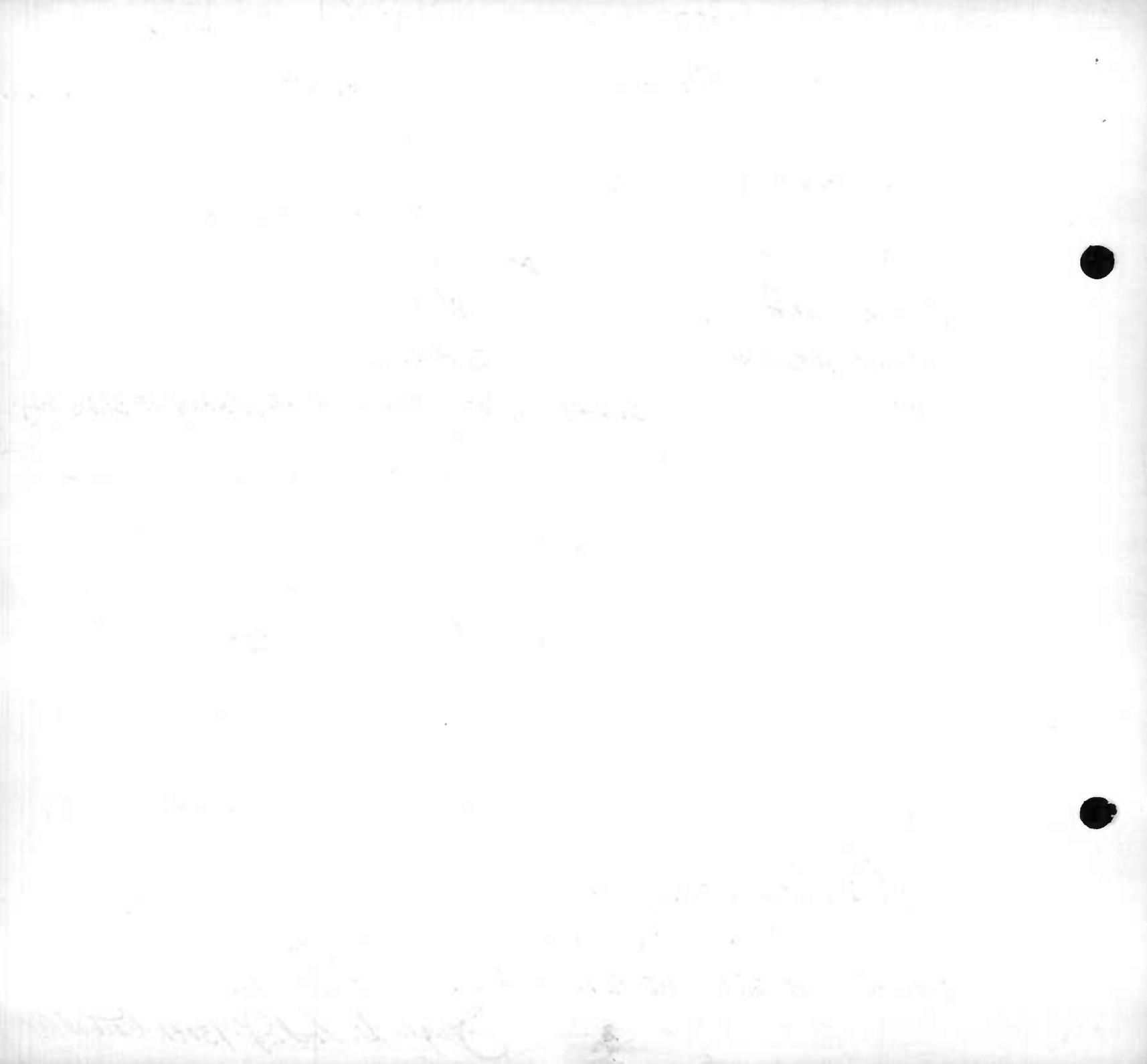
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-425		71 12132	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12132
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/29/71		5:47 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  The Johns Hopkins Hospital <i>33</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1002			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female RACE Negro		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		7. DATE OF BIRTH 9/6/00 8. AGE (in years lost birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurses aid</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME Jonas Hanes		14. MOTHER'S MAIDEN NAME SARAH		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-1499		17. INFORMANT Harry Wilson Jr Rte 1 Washington Bladensburg ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>450X I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>short</i>	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>prob. Acute MI</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION listed.		(B) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <i>prob. ful. Cardiac</i> <i>Cellulitis of O leg</i>		<i>4 days</i>	
MEDICAL CERTIFICATION <i>O</i>		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/28</i> to <i>12/29</i> 1971 that (I) (we) last saw the deceased alive on <i>12/29</i> 1971 and that (In my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert L. Roper MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/29/71</i>	
23C. PHYSICIAN'S NAME (Type) Daniel L. Roper, M.D.		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/71</i>		24C. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. LOCATION (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Joseph G. Docks Jr</i>	
ADDRESS <i>1304 N Central St</i>					



1  
H-560

71 12133

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12133

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

David O. Henry

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

6. SEX

Male

7. RACE

Negro

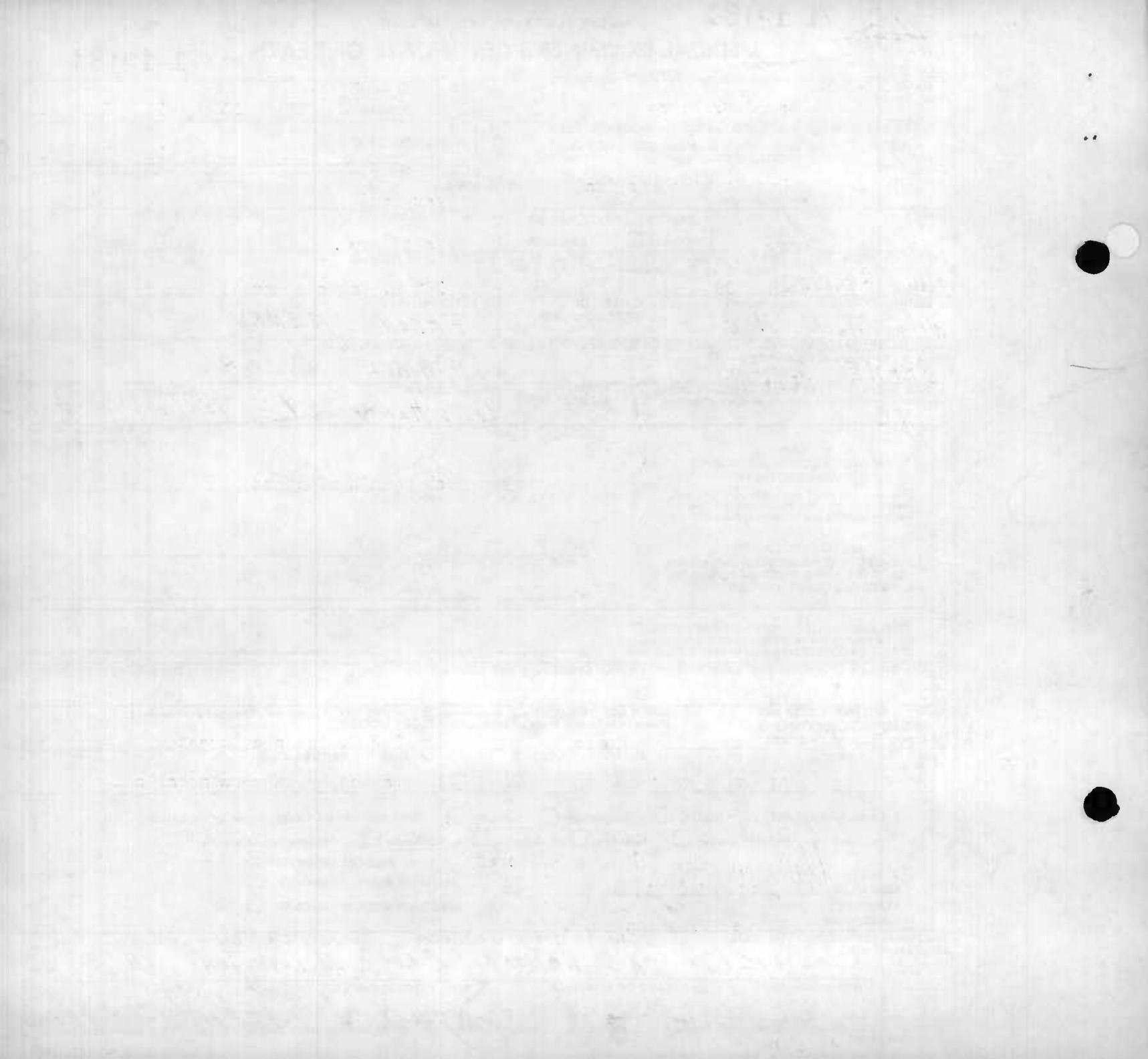
8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Aug 26, 1932

39



## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-652  
BIRTH NO

71 12134

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

71 12134

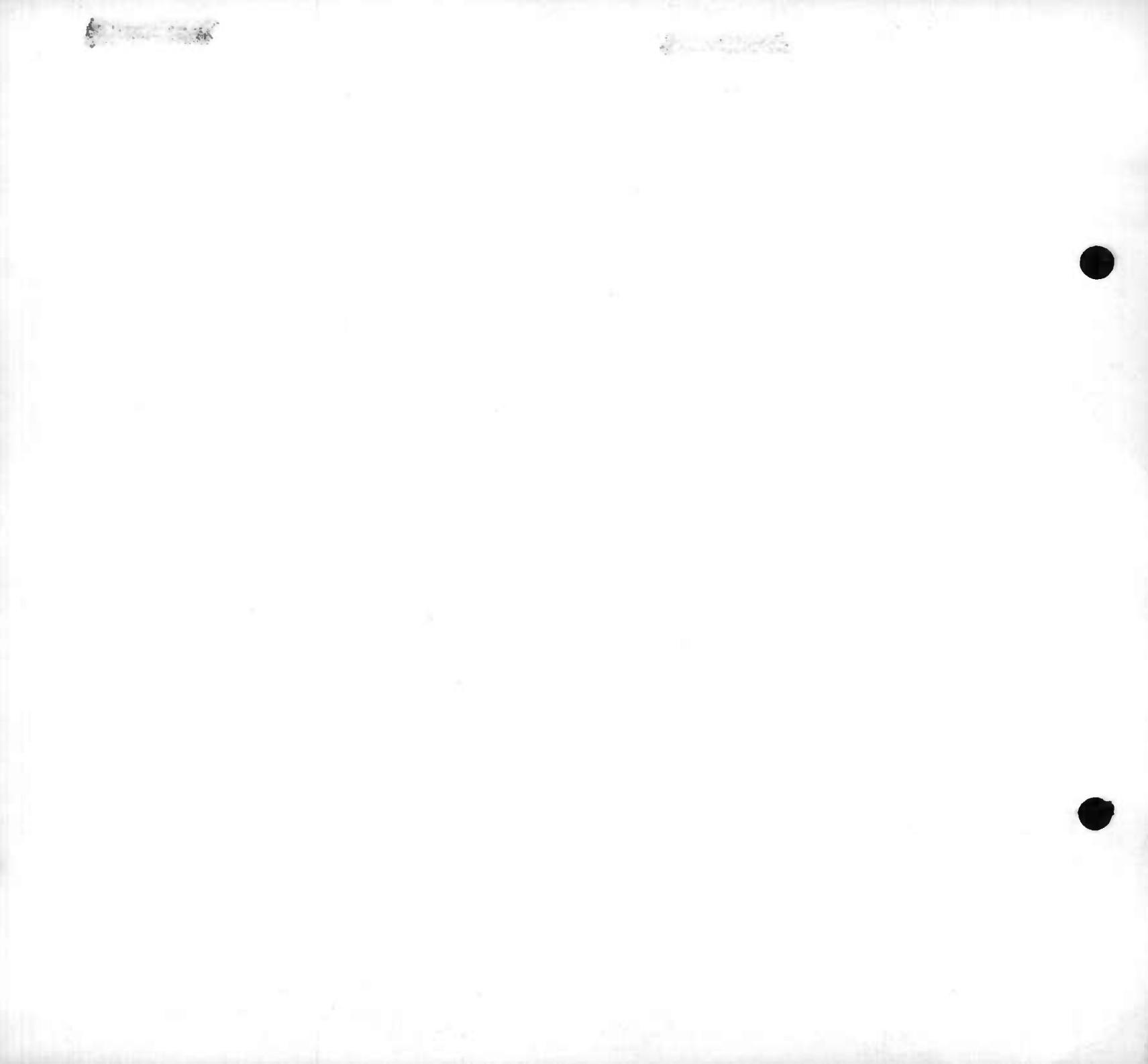
1. NAME OF DECEASED (Type or Print) Sorenson, Christina C		2. DATE AND HOUR OF DEATH 12/27/71 6:05 pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital Emergency Room Wilkens and Caton Ave 21229		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE Md. B. COUNTY A.A.	
		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 11 Wallace Ave 21225	
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years lost birthday) 87
13. FATHER'S NAME Charles Wortman		11. BIRTH PLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 52 7898	17. INFORMANT Ethel Campbell, 109 Hammonds Lane
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Due to, or as a consequence of: Cerebral Vascular Accident  (B) DUE TO, OR AS A CONSEQUENCE OF: Artherosclerosis  (C)...	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Hours.	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/27/71 to 12/27/71, and that (I) (we) last saw the deceased alive on 12/27/71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Paul R Ziegler MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/27/71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/30/71	24C. NAME of CEMETERY or CREMATORIUM Loudon Park Cemetery	24D. LOCATION (City, town, or county) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR George J. Gonce, 4001 Ritchie Hwy.,	25C. FUNERAL DIRECTOR ADDRESS



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-142		71 12135		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
BIRTH NO.		2. DATE AND HOUR OF DEATH		71 12135		16:30 A. M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		12/29/71	
Franklin Peoples		J. Peoples		A. STATE & COUNTY		Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
University of Maryland Hospital 38		Baltimore		E. STREET AND NUMBER		706 N. Gilmore Street	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		Black		7/8/16		9. AGE (in years lost birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Janitor		Sparrows Point Plant		North Carolina		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Joseph Peoples		Unk.		NO		243-20-8713	
18. I		CAUSE OF DEATH		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Gram Negative Sepsis DUE TO, OR AS A CONSEQUENCE OF:		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. I certify that (I) (this hospital) attended the deceased from Dec. 15 1971 to Dec. 29 1971 that (I) (we) last saw the deceased alive on Dec. 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) Pseudomonas Peritonitis, Pneumonia DUE TO, OR AS A CONSEQUENCE OF:		23. SIGNATURE		24. BURIAL, CREMATION, REMOVAL (Specify)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF:		25. PHYSICIAN'S NAME (Type)		26. DATE REC'D BY HEALTH DEPT.	
II		20A. AUTOPSY? (Yes or No)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21H. DATE SIGNED	
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21I. ATTENDING PHYS. DEGREE		21J. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/>		12/29/71	
21C. WHERE DID INJURY OCCUR?		22C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24B. DATE	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22D. NAME OF CEMETERY OR CREMATORIUM		24C. NAME OF CEMETERY OR CREMATORIUM		24D. LOCATION (City, town, or county)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22E. NAME OF REGISTRAR		24E. DEGREE		25C. FUNERAL DIRECTOR ADDRESS	
21F. HOW DID INJURY OCCUR?		22F. DEGREE		24F. LOCATION (State)		25D. DATE REC'D BY FUNERAL DIRECTOR ADDRESS	
21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22G. DEGREE		24G. DEGREE		25E. FUNERAL DIRECTOR ADDRESS	
21H. DATE SIGNED		22H. DEGREE		24H. DEGREE		25F. FUNERAL DIRECTOR ADDRESS	
21I. ATTENDING PHYS. DEGREE		22I. DEGREE		24I. DEGREE		25G. FUNERAL DIRECTOR ADDRESS	
21J. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>		22J. DEGREE		24J. DEGREE		25H. FUNERAL DIRECTOR ADDRESS	
22A. DATE REC'D BY HEALTH DEPT.		22B. NAME OF REGISTRAR		24B. DATE		25B. NAME OF REGISTRAR	
22C. PHYSICIAN'S NAME (Type)		22D. ADDRESS		24C. NAME OF CEMETERY OR CREMATORIUM		25C. FUNERAL DIRECTOR ADDRESS	
22E. NAME OF REGISTRAR		22F. DEGREE		24D. LOCATION (City, town, or county)		25D. DATE REC'D BY FUNERAL DIRECTOR ADDRESS	
22G. DEGREE		22H. DEGREE		24E. DEGREE		25E. FUNERAL DIRECTOR ADDRESS	
22I. DEGREE		22J. DEGREE		24F. DEGREE		25F. FUNERAL DIRECTOR ADDRESS	
22J. DEGREE		22K. DEGREE		24G. DEGREE		25G. FUNERAL DIRECTOR ADDRESS	
22K. DEGREE		22L. DEGREE		24H. DEGREE		25H. FUNERAL DIRECTOR ADDRESS	
22L. DEGREE		22M. DEGREE		24I. DEGREE		25I. FUNERAL DIRECTOR ADDRESS	
22M. DEGREE		22N. DEGREE		24J. DEGREE		25J. FUNERAL DIRECTOR ADDRESS	
22N. DEGREE		22O. DEGREE		24K. DEGREE		25K. FUNERAL DIRECTOR ADDRESS	
22O. DEGREE		22P. DEGREE		24L. DEGREE		25L. FUNERAL DIRECTOR ADDRESS	
22P. DEGREE		22Q. DEGREE		24M. DEGREE		25M. FUNERAL DIRECTOR ADDRESS	
22Q. DEGREE		22R. DEGREE		24N. DEGREE		25N. FUNERAL DIRECTOR ADDRESS	
22R. DEGREE		22S. DEGREE		24O. DEGREE		25O. FUNERAL DIRECTOR ADDRESS	
22S. DEGREE		22T. DEGREE		24P. DEGREE		25P. FUNERAL DIRECTOR ADDRESS	
22T. DEGREE		22U. DEGREE		24Q. DEGREE		25Q. FUNERAL DIRECTOR ADDRESS	
22U. DEGREE		22V. DEGREE		24R. DEGREE		25R. FUNERAL DIRECTOR ADDRESS	
22V. DEGREE		22W. DEGREE		24S. DEGREE		25S. FUNERAL DIRECTOR ADDRESS	
22W. DEGREE		22X. DEGREE		24T. DEGREE		25T. FUNERAL DIRECTOR ADDRESS	
22X. DEGREE		22Y. DEGREE		24U. DEGREE		25U. FUNERAL DIRECTOR ADDRESS	
22Y. DEGREE		22Z. DEGREE		24V. DEGREE		25V. FUNERAL DIRECTOR ADDRESS	
22Z. DEGREE		22AA. DEGREE		24W. DEGREE		25W. FUNERAL DIRECTOR ADDRESS	
22AA. DEGREE		22AB. DEGREE		24X. DEGREE		25X. FUNERAL DIRECTOR ADDRESS	
22AB. DEGREE		22AC. DEGREE		24Y. DEGREE		25Y. FUNERAL DIRECTOR ADDRESS	
22AC. DEGREE		22AD. DEGREE		24Z. DEGREE		25Z. FUNERAL DIRECTOR ADDRESS	
22AD. DEGREE		22AE. DEGREE		24AA. DEGREE		25AA. FUNERAL DIRECTOR ADDRESS	
22AE. DEGREE		22AF. DEGREE		24AB. DEGREE		25AB. FUNERAL DIRECTOR ADDRESS	
22AF. DEGREE		22AG. DEGREE		24AC. DEGREE		25AC. FUNERAL DIRECTOR ADDRESS	
22AG. DEGREE		22AH. DEGREE		24AD. DEGREE		25AD. FUNERAL DIRECTOR ADDRESS	
22AH. DEGREE		22AI. DEGREE		24AE. DEGREE		25AE. FUNERAL DIRECTOR ADDRESS	
22AI. DEGREE		22AJ. DEGREE		24AF. DEGREE		25AF. FUNERAL DIRECTOR ADDRESS	
22AJ. DEGREE		22AK. DEGREE		24AG. DEGREE		25AG. FUNERAL DIRECTOR ADDRESS	
22AK. DEGREE		22AL. DEGREE		24AH. DEGREE		25AH. FUNERAL DIRECTOR ADDRESS	
22AL. DEGREE		22AM. DEGREE		24AI. DEGREE		25AI. FUNERAL DIRECTOR ADDRESS	
22AM. DEGREE		22AN. DEGREE		24AJ. DEGREE		25AJ. FUNERAL DIRECTOR ADDRESS	
22AN. DEGREE		22AO. DEGREE		24AK. DEGREE		25AK. FUNERAL DIRECTOR ADDRESS	
22AO. DEGREE		22AP. DEGREE		24AL. DEGREE		25AL. FUNERAL DIRECTOR ADDRESS	
22AP. DEGREE		22AQ. DEGREE		24AM. DEGREE		25AM. FUNERAL DIRECTOR ADDRESS	
22AQ. DEGREE		22AR. DEGREE		24AN. DEGREE		25AN. FUNERAL DIRECTOR ADDRESS	
22AR. DEGREE		22AS. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22AS. DEGREE		22AT. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22AT. DEGREE		22AU. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22AU. DEGREE		22AV. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22AV. DEGREE		22AW. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22AW. DEGREE		22AX. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22AX. DEGREE		22AY. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22AY. DEGREE		22AZ. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22AZ. DEGREE		22BA. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22BA. DEGREE		22BB. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22BB. DEGREE		22BC. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22BC. DEGREE		22BD. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22BD. DEGREE		22BE. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22BE. DEGREE		22BF. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22BF. DEGREE		22BG. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22BG. DEGREE		22BH. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22BH. DEGREE		22BI. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22BI. DEGREE		22BJ. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22BJ. DEGREE		22BK. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22BK. DEGREE		22BL. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22BL. DEGREE		22BM. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22BM. DEGREE		22BN. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22BN. DEGREE		22BO. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22BO. DEGREE		22BP. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22BP. DEGREE		22BQ. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22BQ. DEGREE		22BR. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	
22BR. DEGREE		22BS. DEGREE		24AP. DEGREE		25AP. FUNERAL DIRECTOR ADDRESS	
22BS. DEGREE		22BT. DEGREE		24AQ. DEGREE		25AQ. FUNERAL DIRECTOR ADDRESS	
22BT. DEGREE		22BU. DEGREE		24AR. DEGREE		25AR. FUNERAL DIRECTOR ADDRESS	
22BU. DEGREE		22BV. DEGREE		24AS. DEGREE		25AS. FUNERAL DIRECTOR ADDRESS	
22BV. DEGREE		22BW. DEGREE		24AO. DEGREE		25AO. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

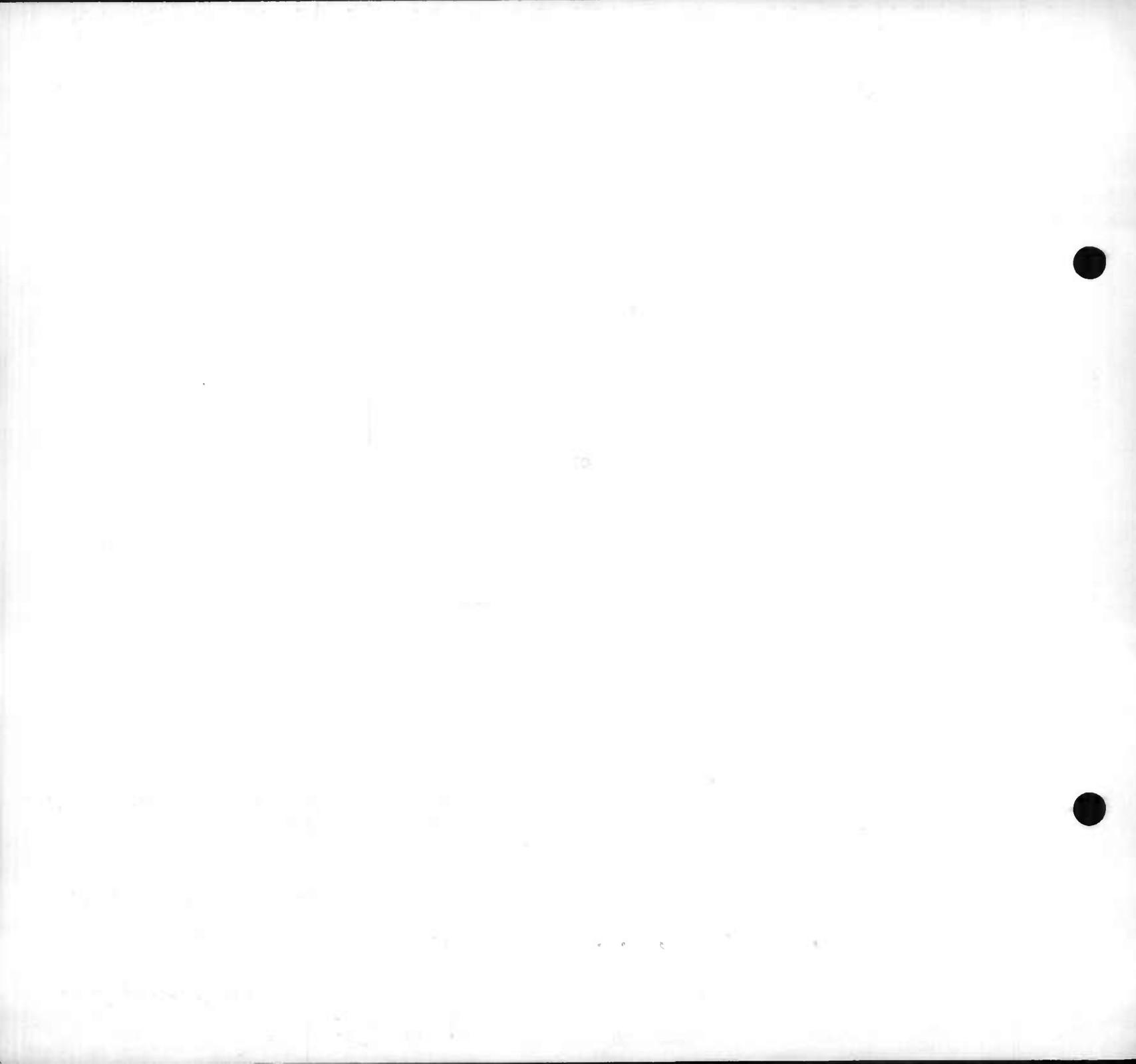
T-000		71 12136		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12136	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 7:50 PM 12/29/71		M.	
1. NAME OF DECEASED (Type or Print) <i>Towe, Elizabeth</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE & COUNTY <i>Maryland</i>		2. DATE AND HOUR OF DEATH 7:50 PM 12/29/71		2. DATE AND HOUR OF DEATH 7:50 PM 12/29/71	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-6-1893</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		9. AGE (in years last birthday) <i>78 yrs</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John Harris</i>		14. MOTHER'S MAREN NAME <i>Mary Ellen Marine</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-07-71188</i>		17. INFORMANT <i>Marcellous Towe 2523 Calverton Hgt.</i>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CEREBRAL METASTASIS?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma Breast</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>-</i>		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		-		-		-	
MEDICAL CERTIFICATION 21A. DATE OF OPERATION		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		-	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -		-	
22. I certify that (1) (this hospital) attended the deceased from <i>12-18-71</i> to <i>12-28-71</i> that (1) (we) last saw the deceased alive on <i>12-29-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		-		-		-	
23A. SIGNATURE <i>Amayr Memon M.D.</i>		23B. DATE SIGNED <i>12-29-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Abdul MA JID MEMON M.D.</i>		23D. ADDRESS <i>730 Ashburton St Balt 21216</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-4-72</i>		24C. NAME OF CEMETERY OR CREMATORIUM <i>Rock Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Cambridge, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 8 1972</i>		25B. NAME OF REGISTRAR <i>Charles A. Rice</i>		25C. FUNERAL DIRECTOR <i>661 W. Barre St</i>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-432 71 12137		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12137			
BIRTH NO.		2. DATE AND HOUR OF DEATH <i>Dec 25, 1971</i>		6 P.M.			
1. NAME OF DECEASED (Type or Print) <i>Estella Shields</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		908			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <i>Harbor View Nursing Home 1213 Light St</i>		A. STATE <i>Md</i> B. COUNTY <i>Baltimore City</i>					
5. SEX <i>F</i>		6. RACE <i>Negro</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-11-02</i>		9. AGE (in years last birthday) <i>69</i>		11. Under 1 Yr. Months Days Hours 12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Horace Wilmer</i>		14. MOTHER'S MAIDEN NAME <i>Martie Foote</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>215-32-2602</i>	
17. INFORMANT <i>Mrs. Maggie Jerdon 2529 Garrett Ave</i>		18. CAUSE OF DEATH <b>Cerebrovascular Accident</b>		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Advanced ASCVD with Transient Ischemic Attacks</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ischemic Attacks</b>			
(C) _____		(D) _____		(E) _____			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED Whilo At <input type="checkbox"/> Not Whilo At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>30 March 1971 to 24 December 1971</b> that (I) <del>last</del> last saw the deceased alive on <b>24 December 1971</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) <del>not</del> <b>view</b> the body after death.	
23A. SIGNATURE <i>Peter H. Rheinstein, M.D.</i>		23B. DATE SIGNED <b>27 Dec 1971</b>		23C. PHYSICIAN'S NAME (Type) <i>Peter H. Rheinstein, M.D.</i>		23D. ADDRESS <i>Harbor View Convalescent Center</i>	
24A. BURIAL CREMATION, DATE REMOVAL (Specify) <i>Burial 12-29-71</i>		24C. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>W.H. E. J. C. 1000</i>		25C. FUNERAL DIRECTOR <i>P-A-Rice 661 Barn ST</i>		ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 71 12138

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

71 12138

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Rossie White

12. DATE AND HOUR OF DEATH

December 22, 1971 8:25 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER

2025 W. Fayette St.

5. SEX

Male Black

6. RACE

Black

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

9/25/02

9. AGE (in years  
last birthday) 69

If Under 1 Yr.  
Months

Days

If Under 24 Hrs.  
Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Walter White

14. MOTHER'S MAIDEN NAME

Victoria Harris

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL SECURITY NO.

217-03-7694

17. INFORMANT Robena B. White 2514 Huron St.

ADDRESS

18. 41231 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) slowing the  
UNDERLYING CONDITION (B).

(A) IMMEDIATE CAUSE Cardio respiratory arrest  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:  
Arterio sclerotic heart disease

(C) Uraria

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
min.

years

days.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

MEDICAL CERTIFICATION

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work  Not While  
At Work

22. I certify that (I) (this hospital) attended the deceased from 12-6, 1971 to 12-22, 1971  
that (I) (we) last saw the deceased alive on 12-22-1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bonith

MD  
DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

12-22-71

23C. PHYSICIAN'S  
NAME (Type)

BONITH

MD  
DEGREE

23D. ADDRESS

Bon Secours Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-28-71

24C. NAME OF CEMETERY OR CREMATORIUM

Mt. Auburn

24D. LOCATION  
(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D. BY HEALTH DEPT.

JAN 3 1972

25B. NAME OF REGISTRAR

Robert E. Faber, R.D.

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

661 W. Barre St.

2514 Huron st.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 71 12139

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 12139

BIRTH NO.  
1. NAME OF DECEASED  
(Type or Print)

NICHOLSON - RUFUS (GIVEN NAME)

DATE AND HOUR OF DEATH

Dec 22 1971 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hosp.  
43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES  NO

E. STREET AND NUMBER

1000 Hollins St.

5. SEX

Male Colored

6. RACE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

6-24-04

9. AGE (in years  
less birthday)

67

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Henry Nicholson

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mary Reddick

ADDRESS

420 E. 38th St.

18. 410.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular Accident about 6 weeks

(B) DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

6 weeks

(C) Atherosclerosis

years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

MEDICAL CERTIFICATION

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work  Not While At Work

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_  
that (I) (we) last saw the deceased alive on \_\_\_\_\_ and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

10-16 1971 to 12-22 1971

23A. SIGNATURE

Edmund P. Garvey MD

23B. DATE SIGNED

12-22-71

23C. PHYSICIAN'S  
NAME (Type)

GARVEY MD

23D. ADDRESS

3001 S. Hanover St.  
Baltimore, Maryland 21230

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-28-71

24C. NAME OF CEMETERY OR CREMATORIAL

Mt. Auburn

24D. LOCATION  
(City, town, or county)

Baltimore, Maryland (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1972

25B. NAME OF REGISTRAR

Robert E. Talley Jr. MD

25C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

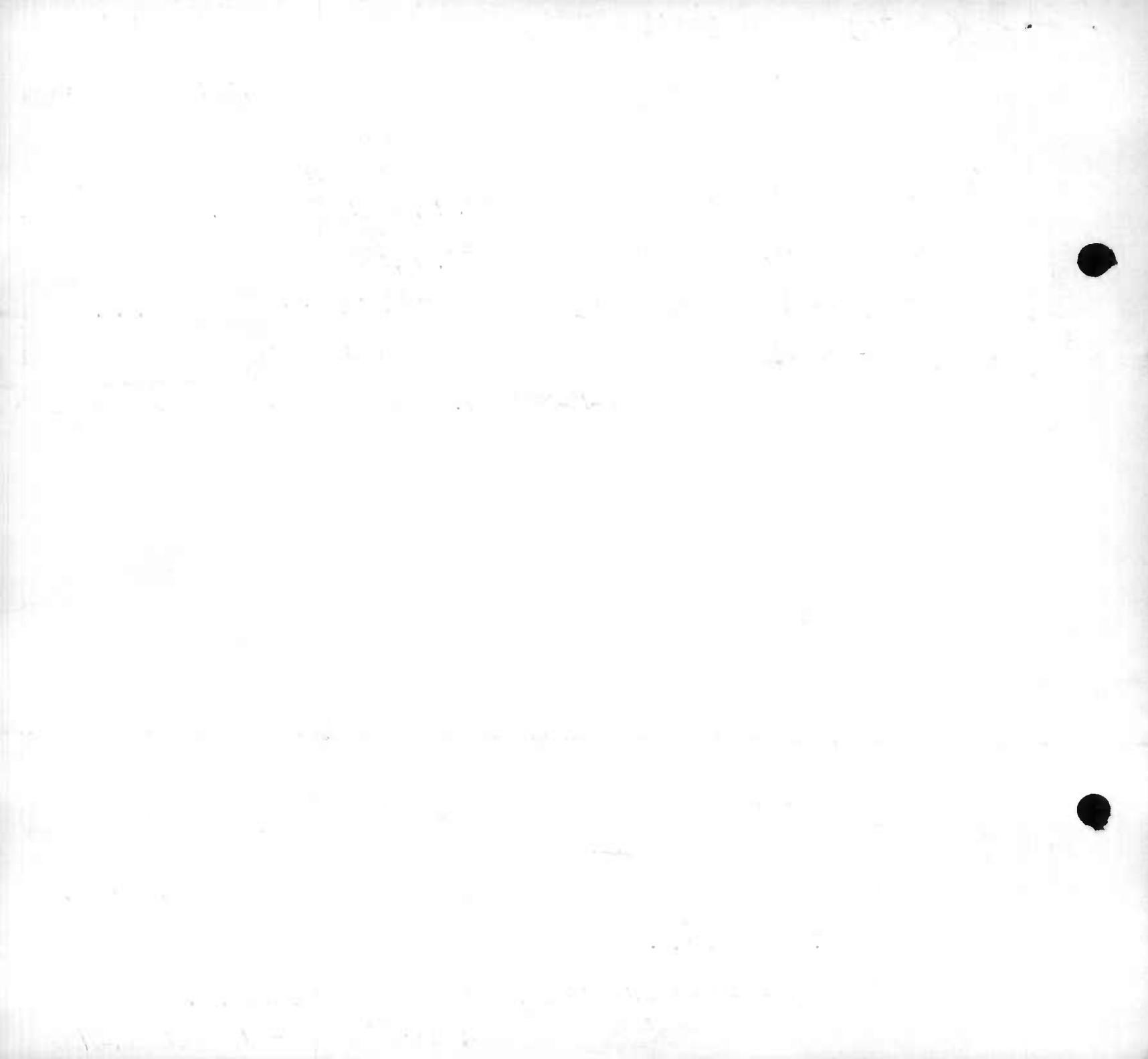
S-610		71 12140	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH X	REG. NO. 71 12140
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/28/71 3 <sup>00</sup> AM M.	
		MARJORIE ANNE SCHARF			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i>		A. STATE MD. CECIL		B. COUNTY 5700	
THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN RISING SUN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		E. STREET AND NUMBER 22 Reynolds Ave.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/03/21		9. AGE (in years last birthday) 50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOSIERY MAKER</i>		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME CARL PULLER		14. MOTHER'S MAIDEN NAME ANNE LOWERS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>70</i>		16. SOCIAL SECURITY NO.		17. INFORMANT MICHAEL P. THUMME DOLPHIN, PA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		ADDRESS	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Metastatic carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: <i>lung metastatic to chest wall, mediastinum</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mos</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <i>2</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 24 1971</i> to <i>12/28 1971</i> that (I) (we) last saw the deceased alive on <i>12/28 1971</i> and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Noble Hansen</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/28/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>NOBLE M. HANSEN</i>		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-31-71</i> 24C. NAME of CEMETERY or CREMATORIUM <i>BROOKVIEW</i>		24D. LOCATION (City, town, or county) (State) <i>RISING SUN, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Walker, R.D.</i>		25C. FUNERAL DIRECTOR <i>Robert E. Walker, R.D.</i> ADDRESS <i>1010 REED FUNERAL HOME RISING SUN</i>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-360		71 12141	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12141		
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH December 26, 1971		11:15 P.M.	
1. NAME OF DECEASED (Type or Print)		Lila Gaither		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY BALTO 5300	
9. Gault Convalescent Home				C. CITY OR TOWN Baltimore 21220		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Rt. 15, Box 315 Chester Rd.			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1906	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		9. AGE (in years last birthday) 65		II Under 1 Yo. Months: Days	II Under 24 Hrs. Hours: Min.
13. FATHER'S NAME - Franklin				11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-3743		14. MOTHER'S MAIDEN NAME Sadie Jennings		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		(A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Multiple Debrile serous & Cachexia. Chronic Brain Hypertension; Parkinson's Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				Yes			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the physician) attended the deceased from _____ that (I) (we) last saw the deceased alive on _____ and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				12/24/1971		12/26/1971	
23A. SIGNATURE Albert B. Bradley		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/28/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 4900 Belair Road 21206					
Albert B. Bradley, M.D.							
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 12-29-71		24C. NAME OF CEMETERY OR CREMATORIAL Orchard Ridge Cemetery		24D. LOCATION (City, town, or county) Pikesville, Md.	
Burial							
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Nealey, M.D.		25C. FUNERAL DIRECTOR John C. Miller Inc-415 Belair Rd. -21206		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 12142
BIRTH NO. L-520 1. NAME OF DECEASED (Type or Print) <b>GERTRUDE M. E. LYNCH</b>		2. DATE AND HOUR OF DEATH Dec. 28, 1971 10 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CERTIFICATE AMENDED</b> 40 St. Agnes Hospital 1-28-72		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2748		
5. SEX female 6. RACE white 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10B. KIND OF BUSINESS OR INDUSTRY Sears Roebuck 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
13. FATHER'S NAME <b>John Andrews</b>		8. DATE OF BIRTH 2/18/92 9. AGE (in years lost birthday) 79 If Under 1 Yr. Months: Days Hours If Under 24 Hrs. Min.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-26-4434 17. INFORMANT Catherine Foss, Dght., above 14. MOTHER'S MAIDEN NAME <b>Ellen Moran</b>		
18. <b>441.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>RUPTURE ANEURYSM, AORTA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCHEROSIS.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 HRS.</b> <b>10 YRS.?</b>		
19A. MEDICAL CERTIFICATION DATE OF OPERATION <b>O</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12/28/71</b> to <b>12/28/71</b> , 1971, and that (I) (we) last saw the deceased alive on <b>12/28/71</b> , 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Paul R. Ziegler M.D.</b>		23B. DATE SIGNED <b>12/30/71</b>		
23C. PHYSICIAN'S NAME (Type) <b>PAUL R. ZIEGLER M.D.</b>		23D. ADDRESS <b>2902 CHESTNUT Hill DR BALTIMORE, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/71</b> 24C. NAME OF CEMETERY or CREMATORIAL <b>Moreland Mem. Park</b> 24D. LOCATION <b>Baltimore, Md.</b> (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Salter, M.D.</b> 25C. FUNERAL DIRECTOR <b>Schimunek, Funeral Home, Inc.</b> ADDRESS <b>3331 Brehms Lane</b>		

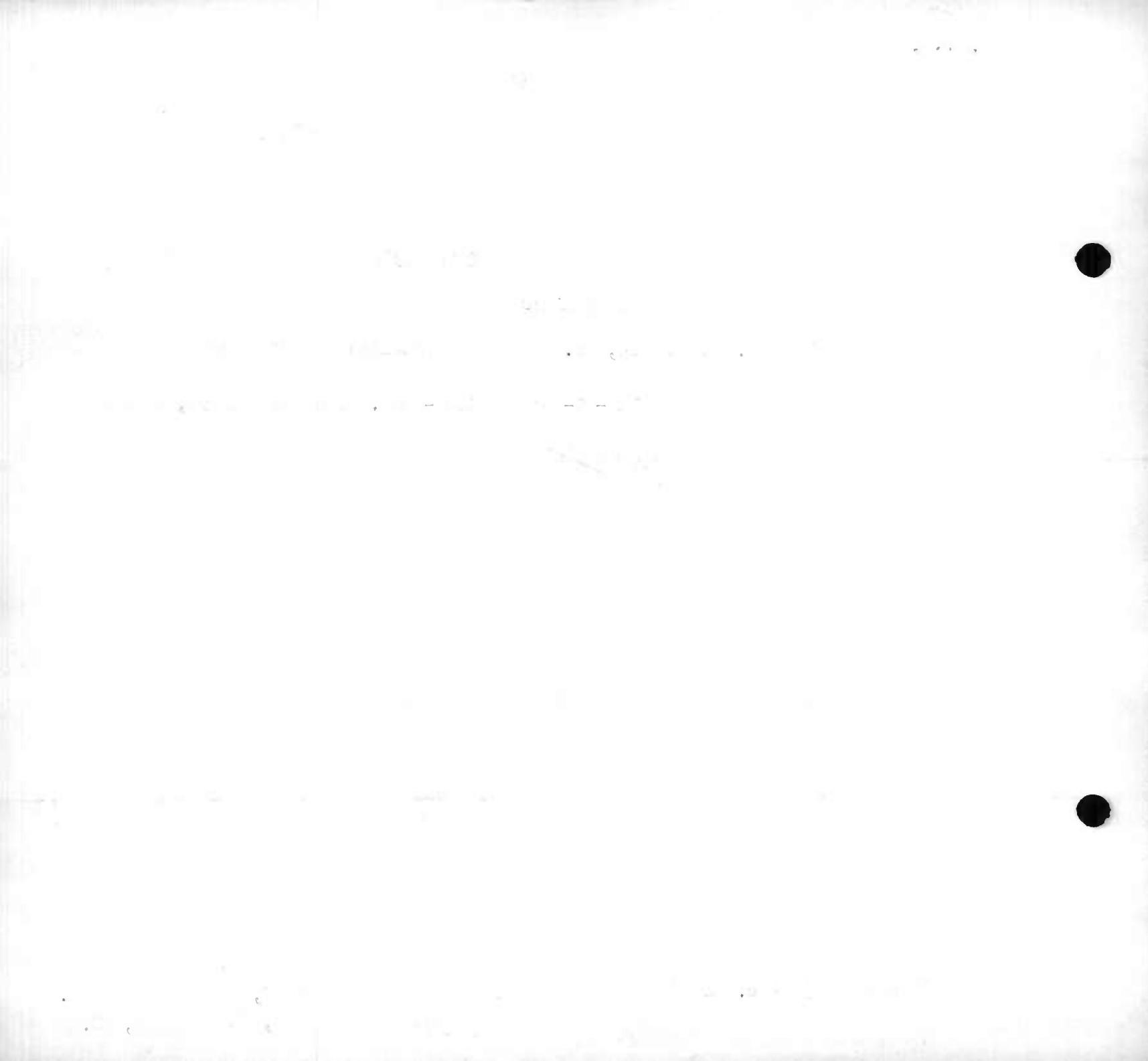
1-28-1972 - Correction Form from Funeral Director - Schimunek Funeral Home, Inc.  
and notification signed by Paul R. Ziegler, M.D.  
200 Chestnut Hill Dr.  
Ellicott City, Maryland

HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-362 71 12143		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12143	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-28-71 13 <sup>0</sup> P.M.			
1. NAME OF DECEASED (Type or Print)		JAMES F. STRAUSBURG, JR.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residenco before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY ANNE ARUNDEL	
48		MD - GEN Hos P		C. CITY OR TOWN CAMBRICLS	
5. SEX M		6. RACE W		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 May 1944		9. AGE (in years less birthday) 27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY Eastern Airlines		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME James F. Strausburg, Sr.		14. MOTHER'S MAIDEN NAME Kathleen Effland		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 217-42-6684		17. INFORMANT Wife - Mrs. Joyce Strausburg, same as 4.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH <i>Autops</i>		ADDRESS	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC MALIGNANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		(D) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(E) _____		(F) _____	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		17-24 19 71 to 12-28 19 71		23A. SIGNATURE <i>Mary E. Strausburg</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Moff		23B. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 31 Dec. 71		24C. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Paul E. Fahey, M.D.		25C. FUNERAL DIRECTOR MARKY J. FURNAL HOME, GLEN BURNIE, MD.	
VS 150-REV. 1/1/68				ADDRESS Md.	



*Barkham*

*Released by approval of Medical Examiner*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-612		71 12144	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			REG. NO. 71 12144
BIRTH NO.					2. DATE AND HOUR OF DEATH 12-24-71 10:15 P.M.	
1. NAME OF DECEASED (Type or Print) <b>Mrs. Nellie Travis</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Keswick Home for Incurables of Baltimore City</b>					C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12-19-86 9. AGE (in years last birthday) 85 yrs. II Under 1 Yr. Months Days Hours III Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady - Hutzler's</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>			11. BIRTHPLACE (State or foreign country) <b>Julian, Florida</b>	
13. FATHER'S NAME <b>George Boston</b>					14. MOTHER'S MAIDEN NAME <b>Henrietta Moore</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. <b>52-05-9260</b>			17. INFORMANT <b>Keswick Home 700 W. 40th. St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fracture of the right hip</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Viral Respiratory Infection</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Influenza &amp; Senility</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>Influenza with Parkinsonism</b>			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Fracture of the right hip</b>					22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>	
23. MEDICAL CERTIFICATION O		24. DATE OF OPERATION WAS PERFORMED			25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>			28. WHERE DID INJURY OCCUR? <b>700 W. 40TH ST.</b>	
29. TIME (Month) (Day) (Year) (Hour) (APPROX.) <b>12-13-71</b>		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			31. HOW DID INJURY OCCUR? <b>FELL TO FLOOR</b>	
32. I certify that (I) (this hospital) attended the deceased from <b>4 Nov</b> to <b>29 Dec</b> , 1971 that (I) (we) last saw the deceased alive on <b>29 Dec</b> , 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					33. DATE SIGNED <b>29 Dec 1971</b>	
34. SIGNATURE <b>Aubrey D. Richardson M.D.</b>		35. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>			36. ADDRESS <b>700 W. 40th St. Baltimore Md 21211</b>	
37. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson M.D.</b>		38. DEGREE			39. ADDRESS	
40. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		41. DATE <b>12/3/71</b>			42. NAME OF CEMETERY OR CREMATORIUM <b>H Funerl Crem</b>	
43. DATE REC'D. BY HEALTH DEPT. <b>JAN 3 1972</b>		44. NAME OF REGISTRAR <b>Robert E. Walker, Jr.</b>			45. LOCATION (City, town, or county) <b>Washington D.C.</b>	
46. FUNERAL DIRECTOR <b>Robert E. Walker, Jr.</b>		47. ADDRESS <b>Severne Ph.D.</b>				

unreliable

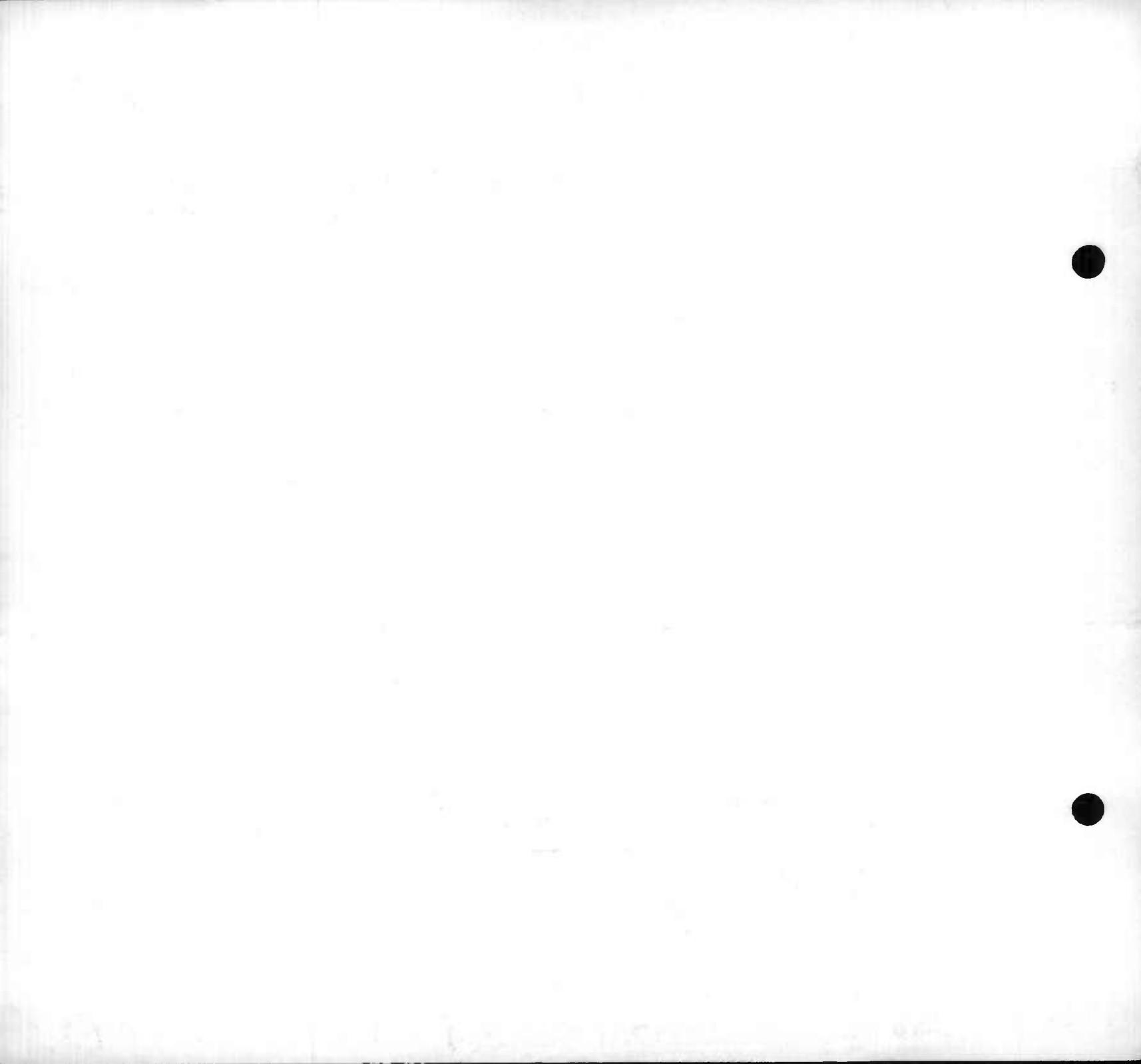
House of Commons of Great Britain  
Minutes of Evidence

→ A. Anderson and about the 15 per cent  
of the members.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400		71 12145	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12145		
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		THOMAS CULLY		2. DATE AND HOUR OF DEATH 12/29/71 1:30 PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  90 Gould Convalescent Home		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 2734		5. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  90 Gould Convalescent Home		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1961 10, 1889		9. AGE (in years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Machine Shop Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Margaret Armstrong	
13. FATHER'S NAME Robert Cully		14. MOTHER'S MAIDEN NAME Margaret Armstrong		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 213-07-9033	
17. INFORMANT George Cully - 6200 Everall Ave		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Perihilar Vasular Damping 2 days	
21A. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? In Baltimore City		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
22. I certify that (I) (We) attended the deceased from _____ to _____ that (I) (We) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		11/30/1971 to 12/29/1971 12/28/1971		23A. SIGNATURE Albert B Bradley		23B. DATE SIGNED 12/29/71	
23C. PHYSICIAN'S NAME (Type)		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	
24B. DATE 12/30/71		24C. NAME OF CEMETERY OR CREMATORIAL London Park Cem.		24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Bradley, Jr.		25C. FUNERAL DIRECTOR John C. Miller Inc.		ADDRESS 6415 Belair Rd.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1. NAME OF DECEASED (Type or Print)		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12146</u>	
IDA MAY HARTKE		2. DATE AND HOUR OF DEATH <u>December 28, 1971</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>Hood Nursing Home</u> <u>5213 Edmondson Avenue 21229</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>Howard</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Elkridge</u>		D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
90		E. STREET AND NUMBER <u>5900 Augustine Avenue</u>			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1880</u>	9. AGE (in years last birthday) <u>91</u>	If Under 1 Yr. Months: Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME  <u>Charles W. Furley</u>		14. MOTHER'S MAIDEN NAME  <u>Ellen Fawver</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  <u>No</u>		16. SOCIAL SECURITY NO.  <u>217-48-9738</u>		17. INFORMANT  <u>Miss Nellie Hartke, 5900 Augustine Ave. 21227</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) siling the UNDERLYING CONDITION lost.					
(A) IMMEDIATE CAUSE <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>A.C.V.D - chronic ischemia</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Generalized - arteritis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>12/27</u> 19 <u>71</u> to <u>11/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>71</u> and that (In my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <u>John H. Hubbard</u>					
23B. DATE SIGNED  <u>12/28/71</u>					
23C. PHYSICIAN'S NAME (Type)  <u>John H. Shew</u>		23D. ADDRESS  <u>820 Edmondson Ave. Baltimore MD 21229</u>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify)  <u>BURIAL</u> <u>12-31-71</u>		24C. NAME OF CEMETERY OR CREMATORIAL  <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county)  <u>Woodlawn, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT.  <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR  <u>John H. Hubbard</u>		25C. FUNERAL DIRECTOR  <u>Howard H. Hubbard, 4107 Wilkins Ave. 21229</u>	
ADDRESS					

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-400 71 12147

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

71 12147

1. NAME OF DECEASED  
(Type or Print)

MAJOR

D. GAYLE, SR.

2. DATE AND HOUR OF DEATH

Dec 27, 1971

5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

LUTHERAN HOSPITAL,  
ASHBURTON ST., BALTIMORE,  
MD 21216.

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
A. STATE & COUNTY

MD

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES  NO

E. STREET AND NUMBER

3635 OLD YORK RD

903

5. SEX

M

6. RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

11-26-93

9. AGE (in years  
last birthday)

78

If Under 1 Yr.  
Months

Days

Hours

If Under 24 Hrs.  
Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maritime Policeman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Mary F. Scruggs, 3847 Autumn Lane

ADDRESS  
Richmond, Va.

18. I 185X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMA OF THE  
PROSTATE.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PROBABLY  
A FEW  
MONTHS.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

PULMONARY EMPHYSEMA.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

While At Work

Not While At Work

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_

that (I) (we) last saw the deceased alive on \_\_\_\_\_ and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Azad Cader*

DEGREE

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

12/27/71

23C. PHYSICIAN'S  
NAME (Type)

AZAD CADER

23D. ADDRESS

LUTHERAN HOSPITAL, BALTO, MD 21216

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-30-71

24C. NAME OF CEMETERY OR CREMATORIUM

Greenmount Cemetery

24D. LOCATION

(City, town, or county)  
Baltimore, Maryland

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 3

1972

R. E. Saber

25B. NAME OF REGISTRAR

R. E. Saber

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

$\pi \rho \omega = 1$

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-600 71 12148		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12148	
BIRTH NO.				2. DATE AND HOUR OF DEATH December 28, 1971 4:05 a.m.	
1. NAME OF DECEASED (Type or Print) <b>ALOIS GEIER</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  <b>OO 625 Brisbane Road Baltimore, Maryland 21229</b>	
				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2531</b>	
				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>625 Brisbane Road</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
				8. DATE OF BIRTH <b>10-10-1889</b>	
				9. AGE (In years last birthday) <b>82</b>	
				If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Heinrich Geier</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>216-28-2732</b>		17. INFORMANT <b>Mr. Carl H. Geier, 278 Cross Creek Drive</b>	
18. <b>410-9</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				ADDRESS <b>21061</b>	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <b>Massive Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF:	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis - A.S. heart disease</b>	
				(C) <b>Sensile</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on <b>Dec. 28 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stanley Ankudas</b>		23B. DATE SIGNED <b>12-28-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>Stanley Ankudas</b>		23D. ADDRESS <b>1101 Maiden Choice Lane, Baltimore, Md. 21229</b>			
24A. BURIAL CREMATION, DATE REMOVAL (Specify) <b>Burial 12-31-71</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Valley, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



71 12149

BALTIMORE CITY HEALTH DEPARTMENT

G-650

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12149

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM F. GROOME

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
1524 W. Pratt Street

2. DATE OF DEATH	Known <input type="checkbox"/>	Month	Day	Year	Hour
Estimated <input type="checkbox"/>					M.

3. DATE PRONOUNCED DEAD	Month	Day	Year	Hour
	December	28	1971	11:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 1902

6. SEX  
Male7. RACE  
White8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

C. CITY OR TOWN	D. INSIDE CITY LIMITS?
Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

9. DATE OF BIRTH  
July 5, 190110. AGE (In years,  
last birthday) 7111. If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

Philadelphia, Penna.

## 12. CITIZEN OF

WHAT COUNTRY? U.S.A.

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Grave Yard Worker

## 14B. KIND OF BUSINESS OR INDUSTRY

Grave Yard

## 15. MOTHER'S MAIDEN NAME

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) If yes, give war or dates of service)

Yes 2-21-20 to 4-30-23

## 17. SOCIAL SECURITY NO.

217-07-6853

## 18. INFORMANT

Catherine Groome

## ADDRESS

1524 W. Pratt Street

## 19. CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## (A) IMMEDIATE CAUSE

DUETO, OR AS A CONSEQUENCE OF:

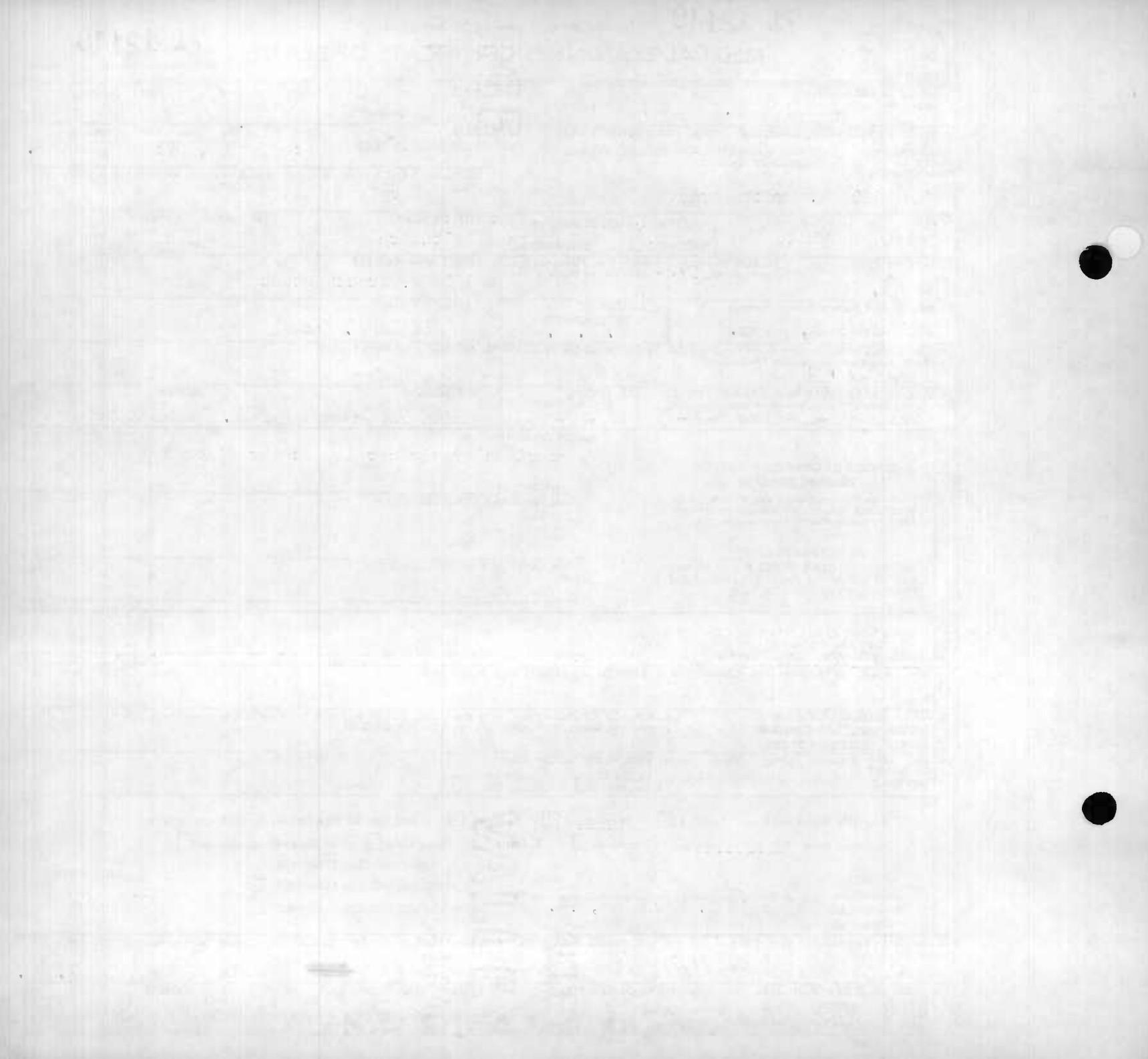
## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).



O-361

71 12150

BALTIMORE CITY HEALTH DEPARTMENT

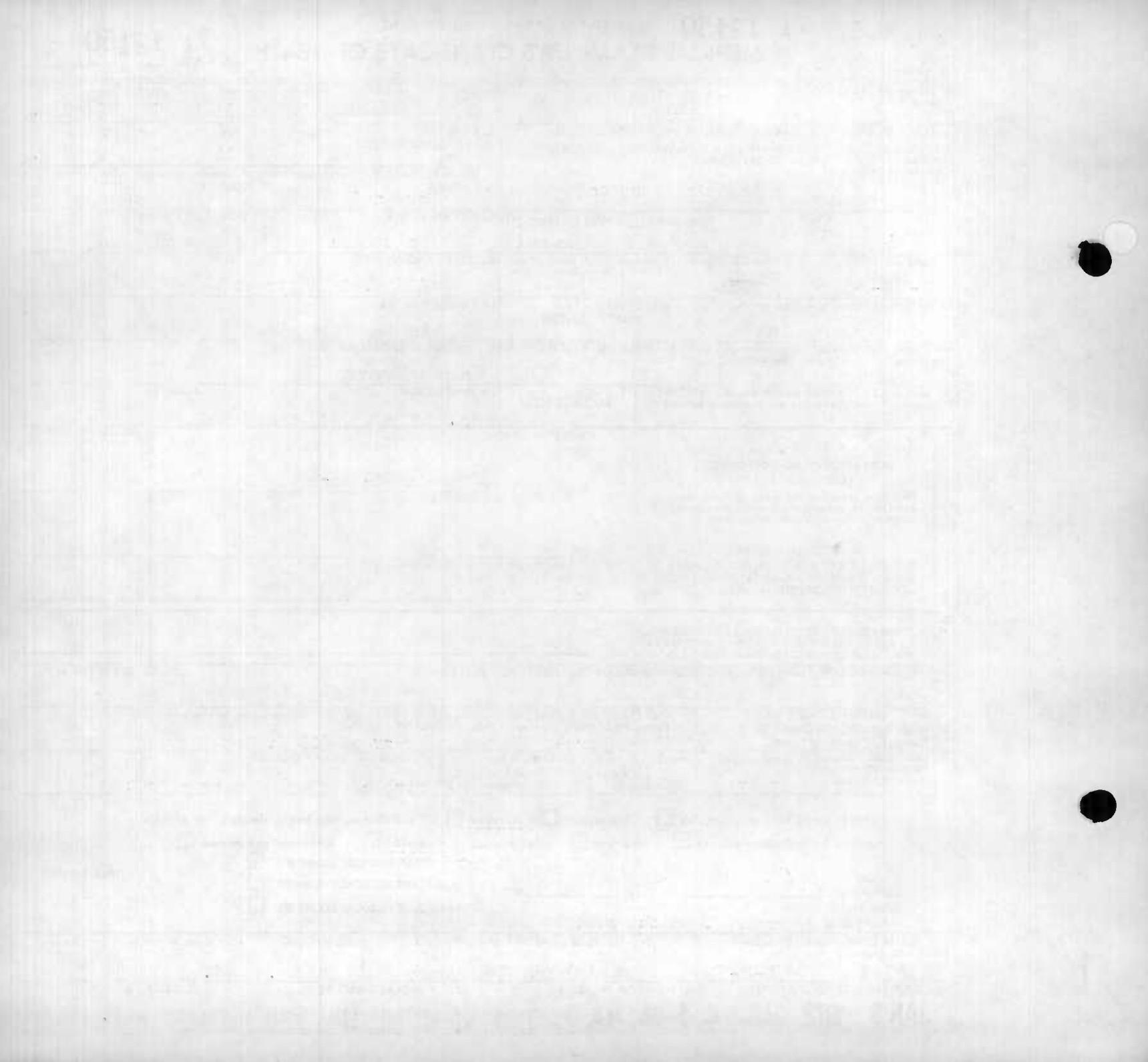
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12150

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Otterbridge Leroy (Otterbridge)		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 31	Year 71	Hour 8:05 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>44</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		3. DATE PRONOUNCED DEAD	Month 12	Day 31	Year 71	Hour 8:05 P.M.
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204					
9. DATE OF BIRTH 9-23-36	10. AGE (In years lost birthday) 35	If Under 1 Yr. <input type="checkbox"/> 11 Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	E. STREET AND NUMBER 425 E. 20th Street					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Sarah Brown					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO.	18. INFORMANT Mrs. Sarah Otterbridge	ADDRESS 425 E 20th St					
19. E 966X		CAUSE OF DEATH	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple stab wounds DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C)						
20A. MEDICAL CERTIFICATION 20. DATE OF OPERATION 1		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes						
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? rear of 433 E. 20th Street 1204				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 17 71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? stabbed by unknown assailant				
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-72		24C. NAME of CEMETERY or CREMATORIAL Mt Auburn Cemetery		24D. LOCATION (City, town, or county) Balto., Md.		DATE SIGNED 1-1-72
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12151	
1. NAME OF DECEASED (Type or Print)		John W. Miller		2. DATE AND HOUR OF DEATH Dec 27 1971 7:30 P M	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md B. COUNTY 2641	
005625 Mayview Ave				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5625 Mayview Ave	
5. SEX M		6. RACE W		8. DATE OF BIRTH APRIL 24 1882	
				9. AGE (in years last birthday) 89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY BAKING FARM		If Under 1 Yr. Months Days Hours Min.	
13. FATHER'S NAME				11. BIRTHPLACE (State or foreign country) Baltimore MD	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-8050		14. MOTHER'S MAIDEN NAME Catherine Miller	
				ADDRESS Some	
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT ASUD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH circulatory failure 3 days 10 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: normal aging			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 2-22 1967 to 12-27 1971	
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on _____ 12-26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED 12-28-71	
23C. PHYSICIAN'S NAME (Type)		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS 1 W. Overlea Ave	
24A. BURIAL CREMATION, DATE REMOVAL (Specify) BURIAL 12-30-71		24C. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		24D. LOCATION (City, town, or county) Baltimore MD	
25A. DATE RECEIVED BY HEALTH DEPT. AN 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Charl. T. Evans & Son 8802 Harbor Rd	
VS 150-REV. 1/1/68					



L-625 71 12152

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12152

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LARKINS, ELIZABETH May

2. DATE AND HOUR OF DEATH

DECEMBER 27, 1971

4:20 P.M.  
2505

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)CERTIFICATE AMENDED  
ST AGNES HOSPITAL 2-16-72

4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN BALTIMORE

D. INSIDE CITY LIMITS?

YES  NO 

E. STREET AND NUMBER

4102 MARIBAN COURT

5. SEX

FEMALE

6. RACE

CAUCASION

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

10 11

87

9. AGE (In years  
(lost birthday))

68

64

If Under 1 Yr.  
Months: DaysII Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W

12. CITIZEN OF WHAT COUNTRY?

DELAWARE Trenton, N. J.

U.S.A.

13. FATHER'S NAME

Charles McCormick

220-68-7488

14. MOTHER'S MAIDEN NAME

Elizabeth McCormick

15. Was Deceased Ever In U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

220-68-7488

17. INFORMANT

BALTIMORE MD 21229

ADDRESS

ST AGNES HOSPITAL CATON &amp; WILKENS AVE

18. I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Acute Myocardial Infarction  
DUE TO, OR AS A CONSEQUENCE OF:(B) Due to, or as a consequence of:  
*ASCVD*

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

NO

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work  Not While  
At Work 22. I certify that  (this hospital) attended the deceased from DECEMBER 25, 19 71 to DECEMBER 27, 19 71  
that  (we) last saw the deceased alive on DECEMBER 27, 19 71 and that in  (my) (our) opinion death occurred on the date  
and hour and from the causes stated above.  (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alonzo G. Vargas Jr. M.D.

DEGREE

23B. DATE SIGNED

12-27-71

23C. PHYSICIAN'S  
NAME (Type)

Alonzo G. Vargas Jr.

23D. ADDRESS

ST AGNES HOSPITAL WILKENS &amp; CATON AVES

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/30/71

24C. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Cemetery

24D. LOCATION  
(City, town, or county)

Glen Burnie, Maryland

STATE

21061

25A. DATE REC'D BY HEALTH DEPT.

JAN 3 1972

Robert E. Johnson, M.D.

25B. NAME OF REGISTRAR

O D O

25C. FUNERAL DIRECTOR

MR. Kelly

ADDRESS

130 E. Fort Avenue

2-16-1972 - Correction form from Funeral Director and letter from The Life Insurance Company  
of Virginia, 1657 Whitehead Court, Baltimore, Md. 21207  
(signed) B. S. Finney  
Representative

And letter from - Dept. of Health, Education & Welfare  
Social Security Administration

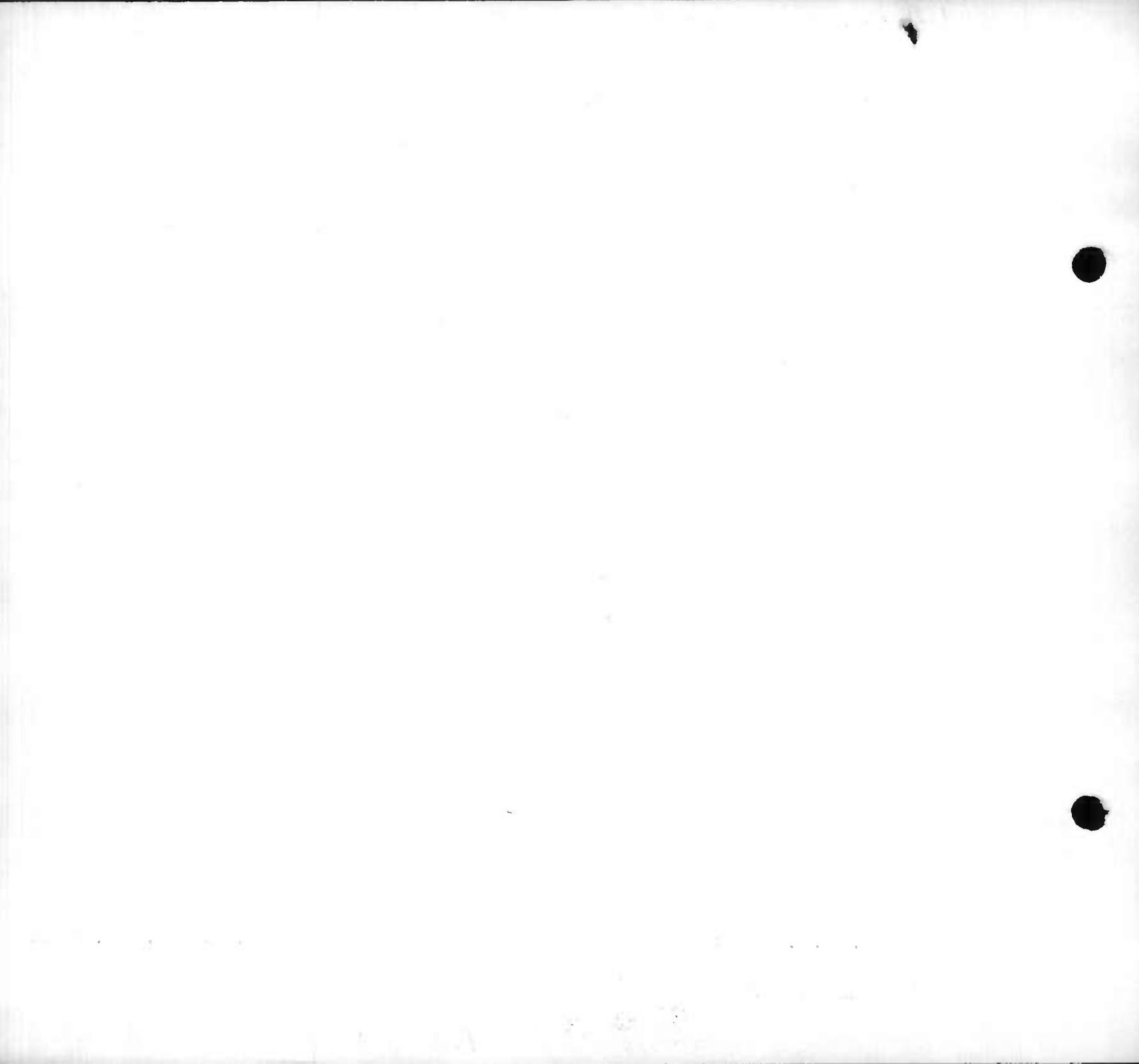
Murray L. Miller, Jr.  
Claims Representative

HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

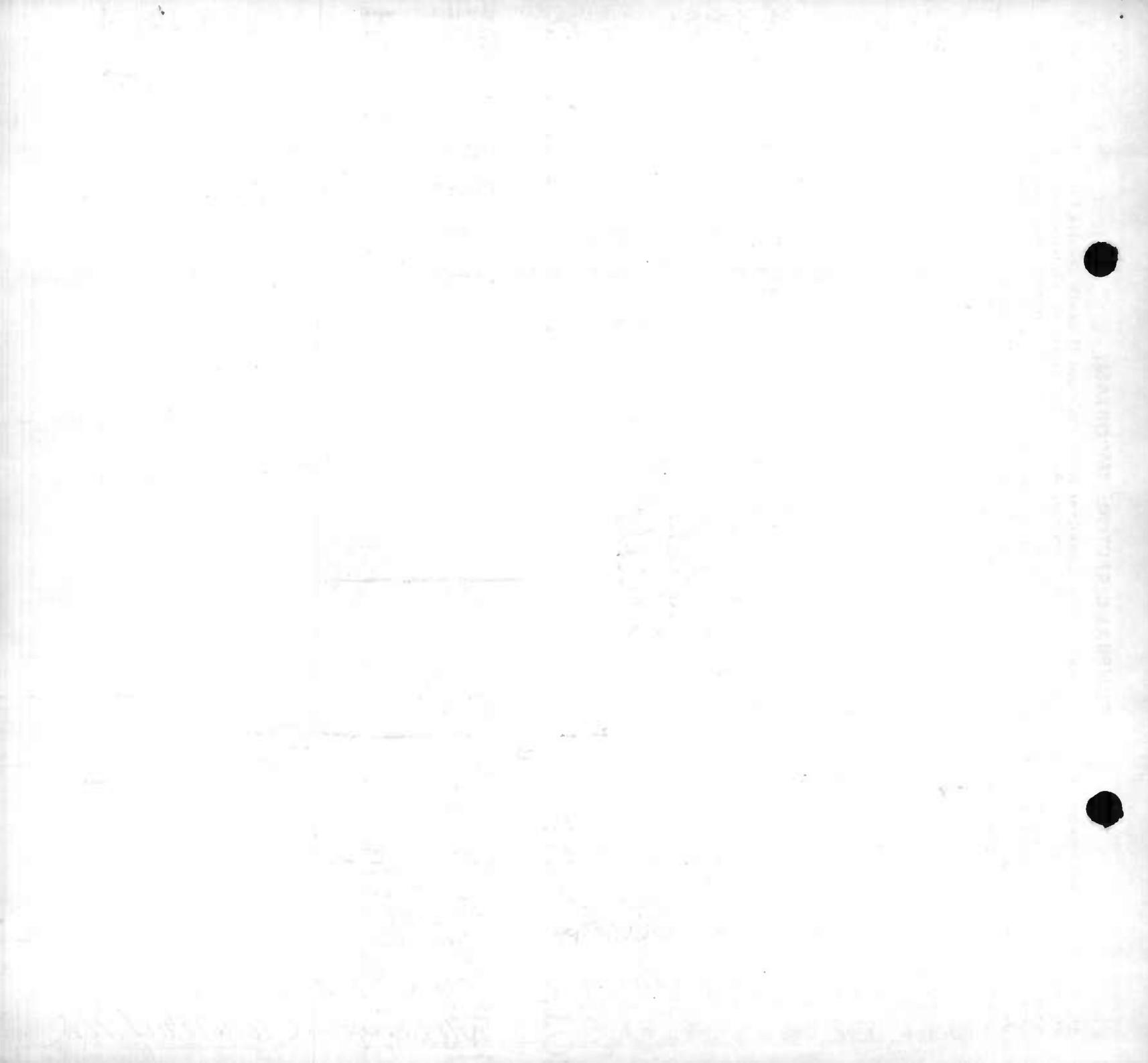
N 520		71 12153		BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO. 71 12153	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
IDA E. NEMEC				12/29/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD.		B. COUNTY 2505	
SOUTH BALTO. HOSP. 43				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-08	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY PRESSER SHIRT FACTORY		9. AGE (in years last birthday) 63		II Under 1 Yr. Months Days Hours II Under 24 Hrs. Min.	
13. FATHER'S NAME MARTIN PRILLER				11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-0920		14. MOTHER'S MAIDEN NAME FANBACK		ADDRESS 4519 Pennington	
18. 410.9 I				19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE Acute Myocardial Infarction, recently DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) A.S.C.V disease DUE TO, OR AS A CONSEQUENCE OF:		5 years	
ANTECEDENT CAUSES				(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?						(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 2/12/71 to 12/29/71 that (I) (we) last saw the deceased alive on 11/16/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/30/71	
J.R. Gehlert MD							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4700 Pennington Ave. Balto. Md. 21226			
Dr. S.R. Gehlert							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORIAL HOLY CROSS		24D. LOCATION (City, town, or county) RITCHIE HWY BALTO. MD.	
BURIAL							
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. J. B. M.D. O.D.		25C. FUNERAL DIRECTOR HAHN, Funeral Home		ADDRESS 4200 Pennington	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12154	BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12154		
1. NAME OF DECEASED (Type or Print)		HILDA GEIGER				2. DATE AND HOUR OF DEATH 12-24-71 1:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE 2748			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		union Memorial Hospital 44				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1892		9. AGE (in years last birthday) 79 II Under 1 Year Months: Days Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? AMERICAN			
13. FATHER'S NAME Theodor Meyer		14. MOTHER'S MAIDEN NAME Olivia Mayer							
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 219 34 4125		17. INFORMANT Mrs Harold Rein 5601 Largo Rd		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardiac Arrest							
(B) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:  UNDERLYING CONDITION							
(C) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(C) DISEASES OR CONDITIONS, if any, giving rise to the above cause (B) stating the UNDERLYING CONDITION last							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11-28-71 to 12-24-71 that (I) (we) last saw the deceased alive on 12-24-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. J. Helou, M.D.		DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-24-71			
23C. PHYSICIAN'S NAME (Type) A. J. HELOU, M.D.		DEGREE		23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/71		24C. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		24D. LOCATION (City, town, or county) BALTIMORE (State) MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert G. Nease		25C. FUNERAL DIRECTOR V. J. DeGrawan		ADDRESS 6067 Half. Rd			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

71 12155

1. NAME OF DECEASED  
(Type or Print)

Charles F. Malcolm, Jr.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

6. SEX

7. RACE

Male

White

8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

9. DATE OF BIRTH

April 12, 1920

10. AGE (In years  
last birthday)

51

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

New York

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

14B. KIND OF BUSINESS OR INDUSTRY

Public Service Comm.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Family records

19. E957X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE Craniocerebral injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

N

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

N

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

bridge

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Frederick Rd. bridge over Beltway

22D. TIME (Month) (Day) (Year) (Hour)  
(APPROX.) 12 21 71 9:50A.m.22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

22F. HOW DID INJURY OCCUR?

jumped from bridge to Beltway

N

I certify that I held an Inquiry  Inspection  Autopsy   
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-21-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

24B. DATE

Dec. 24, 1971

24C. NAME OF CEMETERY or CREMATORIUM

Greenwnt Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 8 1972

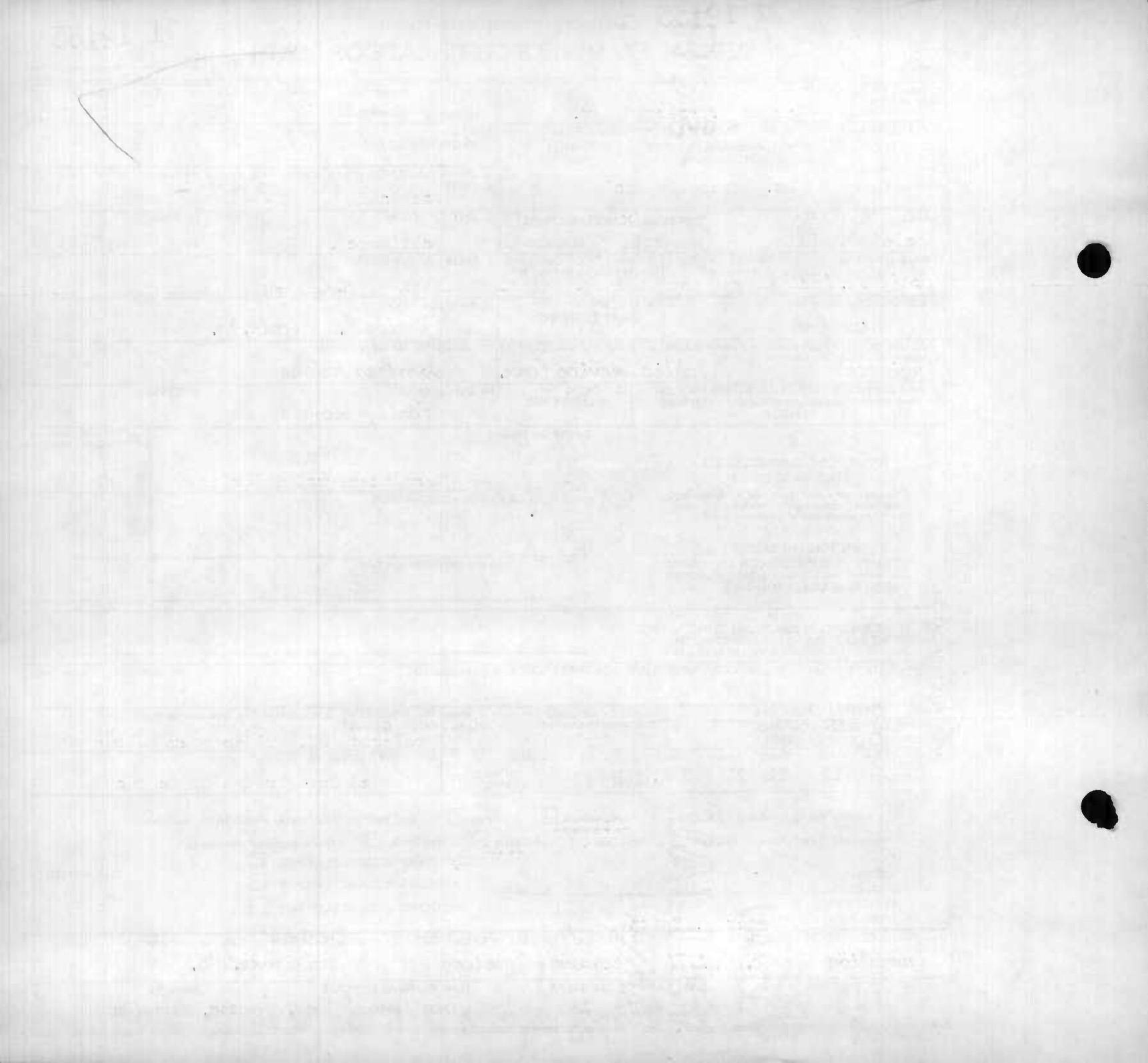
25B. NAME OF REGISTRAR

R. L. Spitz, M.D.

25C. FUNERAL DIRECTOR

John Burns' Sons, Towson, Maryland

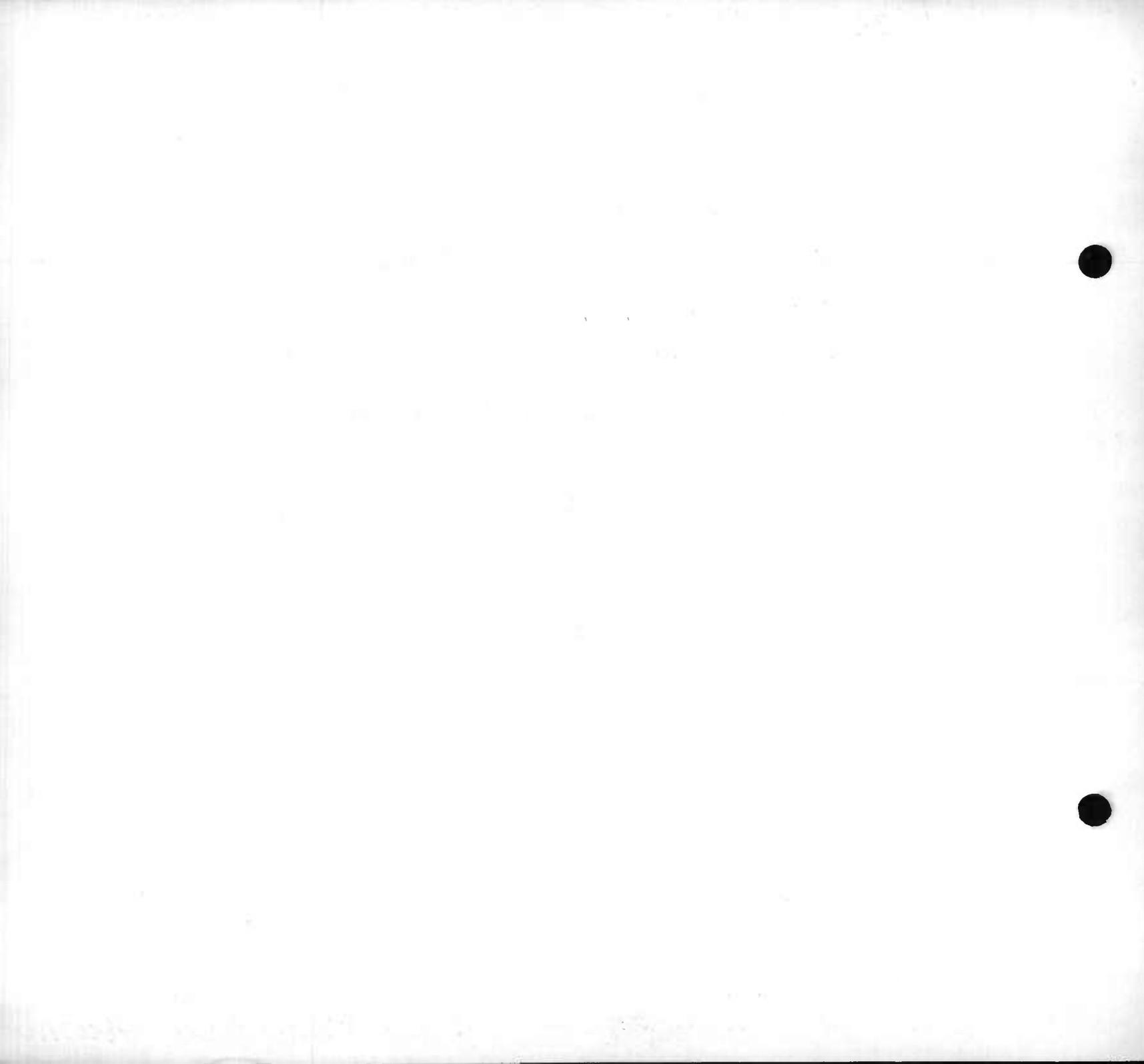
ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

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C-630		71 12156	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12156
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/22/71 2:00 AM		
James Crotty				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Good Samaritan Hospital</i>		A. STATE Maryland B. COUNTY Baltimore 5300		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male		6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1912 9. AGE (in years last birthday) 59 II Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Technologist		10B. KIND OF BUSINESS OR INDUSTRY Can Mfr. Co.		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James F. Crotty		14. MOTHER'S MAIDEN NAME Mary E. Kelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-7334 17. INFORMANT Family records		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH SEPSIS DUE TO, OR AS A CONSEQUENCE OF, BRONCHOPLEURAL FISTULA (B) SEVEROMONTHS PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) POLY MYOSITIS		
19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Intermittent ~1 wk. ~6 wks. 4 mos.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Bronchitis</i>		
20A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, home, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (his hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		11/30 1971 to 12/22 1971		
23A. SIGNATURE <i>Robert P. Jacobs</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/22/71
23C. PHYSICIAN'S NAME (Type) ROBERT P. JACOBS, MD		23D. ADDRESS DEGREE DEGREE 65H, BALT, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE DEGREE Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR DEGREE DEGREE Robert S. Johnson		25C. FUNERAL DIRECTOR ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

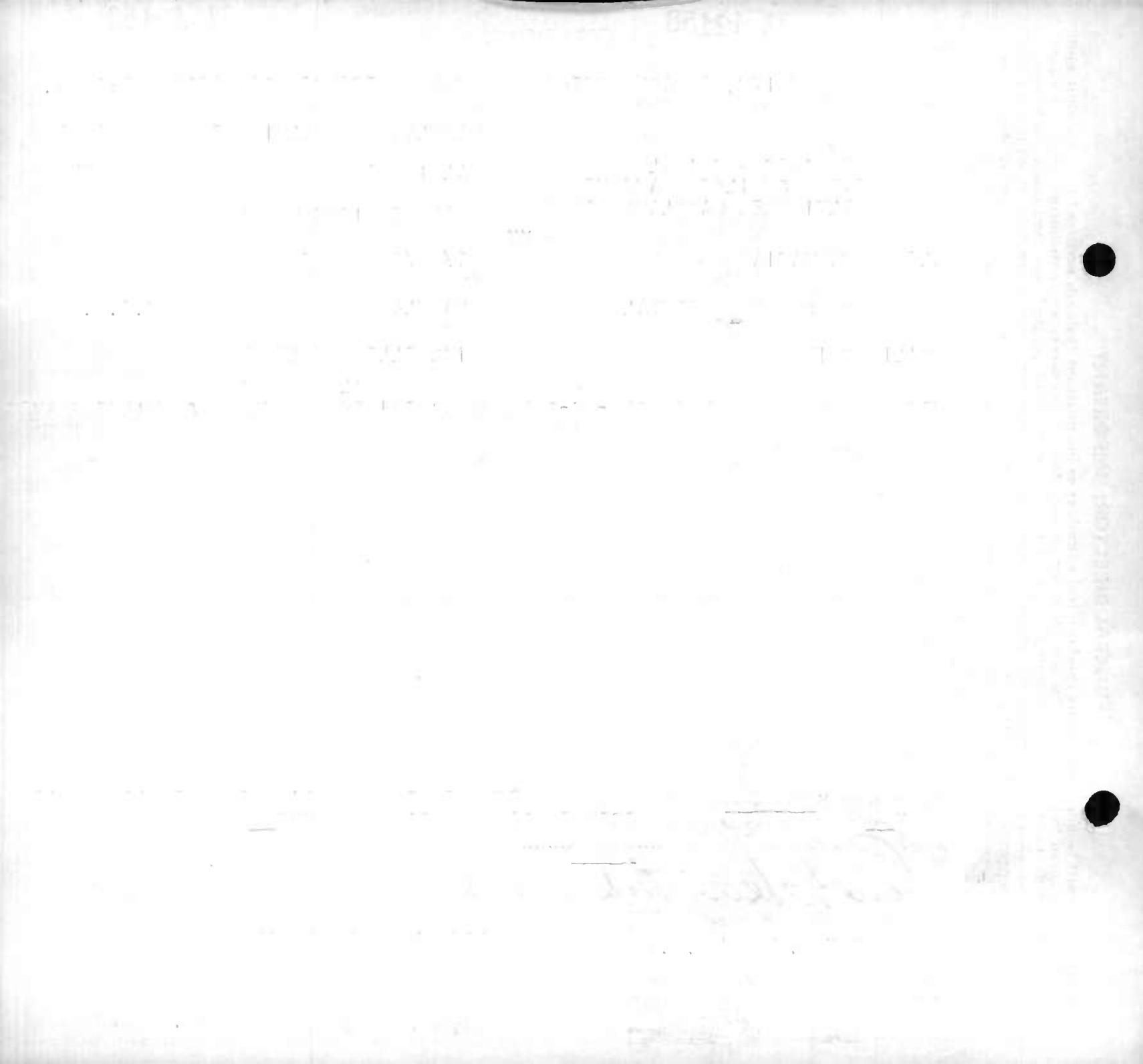
M.E. CASE NO. BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <i>71 12157</i>	
1. NAME OF DECEASED (Type or Print) <b>Minnie B. Miller</b>		2. DATE AND HOUR OF DEATH <i>12/30/71</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <i>90 General German Aged Peoples Home 22 S. Athol Avenue</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2864</i>			
FULL NAME OF HOSPITAL OR INSTITUTION  <i>General German Aged Peoples Home</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
6. RACE <b>white</b>		D. STREET ADDRESS (If rural, give location) <i>22 S. Athol Avenue</i>			
5. SEX <b>female</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <i>9/20/1877</i>	9. AGE (In years lost, birthday) <b>94</b>	If Under 1 Yr. Months, Days	If Under 24 Hrs. Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Gottleib Powolskin (late)</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Powolskin (late)</b>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-54-0687</b>		17. INFORMANT <b>22 S. Athol Avenue</b> <i>21229</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  <i>Cardio Respiratory Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
II ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) DUE TO <i>Malnutrition - Dehydration</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO <i>Carcinoma of Vagina</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1971</i> to <i>30 Dec 1971</i> , that (I) (we) last saw the deceased alive on <i>20 Dec 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William J. Bryson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>30 Dec 71</i>	
23C. PHYSICIAN'S NAME (Type) <i>W J. Bryson</i>		23D. ADDRESS <i>5772 Westview Mall, Baltimore, Maryland</i>			
24A. BURIAL/CREMATION, 24B. DATE REMOVAL (Specify) <b>Burial 1/4/72</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <i>Debbie J. Bryson</i>		25C. FUNERAL DIRECTOR <b>Witke, 1630 Edmondson Ave., 21228</b>	
ADDRESS					
VS 150-REV. 1/1/65					

Adm. to N.H. 10/59.

**FUNERAL DIRECTOR: IMPORTANT**

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S-530		71 12158		BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12158
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		SMITH, EDWARD ROBERT (Schmidt)		2. DATE AND HOUR OF DEATH DECEMBER 31, 1971 1:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE & COUNTY MARYLAND BALTIMORE 21207	
FULL NAME OF HOSPITAL OR INSTITUTION <i>40</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE	
5. SEX MALE		6. RACE CAUCASIAN		E. STREET AND NUMBER 2014 DERRICKSON ROAD <i>5200</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/09/19		9. AGE (In years last birthday) 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) letter carrier		10B. KIND OF BUSINESS OR INDUSTRY POSTAL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PHILIP SMITH		14. MOTHER'S MAIDEN NAME ISABELLE MACKINNON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 218-05-3674		17. INFORMANT BALTO MD 21229	
18. <i>154.1</i>		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMA RECTUM</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Abs &amp; Liver Metastases-Ascites</i>		<i>6 mos</i>	
		(C)			
19. MEDICAL CERTIFICATION		21A. DATE OF OPERATION <i>09/5/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>RESECTION RECTUM</i>	
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) APPROXIMATE		20A. AUTOPSY? (Yes or No) NO	
		21D. TIME OF INJURY (Month Day Year Hour APPROXIMATE)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 30 19 71</b> to <b>DECEMBER 31 19 71</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 31 19 71</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
		23A. SIGNATURE <i>Ronald E. Healy M.D.</i>		23B. DATE SIGNED <i>12/31/71</i>	
		23C. PHYSICIAN'S NAME (Type) ROBERT E. HEALY M.D.		23D. ADDRESS 3350 WILKENS AVENUE	
24A. BURIAL CREMATION, DATE REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIUM Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 8 1972</i>		25B. NAME OF REGISTRAR <i>Ronald E. Healy M.D.</i>		25C. FUNERAL DIRECTOR Witzke, 31630 Edmondson Ave. 21228	
VS 150-REV. 1/1/68				ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		DUFF, James		2 DATE AND HOUR OF DEATH 8:45 AM 12/30/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE & COUNTY Maryland Howard		M. 6300	
5. SEX Male		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/09	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Vice Pres. & Mgr		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A Duff (Late)		14. MOTHER'S MAIDEN NAME Mary Elizabeth Glennon (Late)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown? If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-1358		17. INFORMANT Ellicott City, Md. Mrs. Patricia Duff, Beechwood Road Rt 1		ADDRESS	
18. <i>56931</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Multid. abscess + Enter-cutaneous fistula</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Multiple abscess + Enter-cutaneous fistula</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) .....					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12/30/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Villous adenoma Colon</i>		20A. AUTOPSY? (Yes or No) <i>XXX YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <i>In Baltimore City</i>		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/26/71</i> to <i>12/30/71</i> 19 to 19 that (I) (we) last saw the deceased alive on <i>12/30/71</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>N. Hansen MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/30/71</i>			
23C. PHYSICIAN'S NAME (Type) N. M. Hansen, M.D.		23D. ADDRESS <i>The Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY or CREMATORIUM Mount Olivet		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR 000		25C. FUNERAL DIRECTOR Witzke, 31630 Edmondson Ave., 21228		ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-400		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. _____ 71 12150	
BIRTH NO. 71 12160					
1. NAME OF DECEASED (Type or Print) <i>ANNA TULLY</i>				2. DATE AND HOUR OF DEATH 12/31/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL OF BALTIMORE</i>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>PLEASANT MANOR MURRAY AVE</i>	
				C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>PARK HEIGHTS 2834</i>	
5. SEX <i>F</i> 6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/1/06</i> 9. AGE (in years lost birthday) <i>65</i> If Under 1 Yr. Months: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PETITRED</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U.S.</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>N.A.</i>				14. MOTHER'S MAIDEN NAME <i>N.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215 630-3058</i>		17. INFORMANT  Mrs. Brian Tully 814 Stamford Rd. 21229 ADDRESS	
18. <i>250.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  <i>PULMONARY EDEMA.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 HRS.</i>	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>DIABETIC COMA.</i> <i>DIABETES MELLITUS.</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>KETO ACIDS.</i>		<i>15 + yrs.</i>	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2 NOV</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>YES</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>BALTIMORE (SINAI HOSP.)</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <i>NO.</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N.A.</i>		21C. WHERE DID INJURY OCCUR? <i>N.A.</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <i>NOV 31 1971</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>NOVEMBER 31 1971 to DECEMBER 31 1971</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>NOVEMBER 31 1971</i> to <i>DECEMBER 31 1971</i> , and that (I) (we) last saw the deceased alive on <i>DECEMBER 31 1971</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>T. CONCEPCION M.D.</i>		23B. DATE SIGNED <i>1/1/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>T. CONCEPCION M.D.</i>		23D. ADDRESS <i>3502 W. ROGERS AVE. 21215</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24C. NAME OF CEMETERY or CREMATORIAL <i>New Cathedral</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Tully</i>		25C. FUNERAL DIRECTOR <i>Witzke, 1630 Edmondson Avenue</i>	
				ADDRESS <i>21228</i>	

9/24/71 - Adm. to N. H.  
814 Stamford Rd. 21227

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bady burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-634 71 12161		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. _____ 71 12161	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>BORDLEY JOSEPHINE</b>		2. DATE AND HOUR OF DEATH <b>12-28-71</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>39</b> FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 2600 Liberty Hgts. Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived. II institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2831</b>		5. SEX <b>Female</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>November 25, 96 75</b> 9. AGE (in years last birthday) II Under 1 Yr. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <b>Stevensville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-2680</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Brockington (Daughter)</b> Same	
18. <b>41234</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>A.S.C.V.D</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:  <b>L. CHF</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____		_____	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-28-71</b> to <b>12-28-71</b> , and that (I) (we) last saw the deceased alive on <b>12-28-71</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>R. Mitra</b>		23B. DATE SIGNED <b>12-28-71</b>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>JR R.C. MITRA. MD.</b>		23D. ADDRESS <b>Provident Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>1/2/72</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>STEVENSVILLE Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 3 1972</b>		25B. NAME OF REGISTRAR <b>Robert L. Walker, M.D.</b>		25C. FUNERAL DIRECTOR <b>Mary GEORGE</b>	
				ADDRESS <b>802 Madison Ave.</b>	

$\alpha = \alpha_{\text{min}}$

$$(\alpha^2 - 1) \cos^{-2} \theta = -\sin^2 \theta \cos^{-2} \theta + 1$$

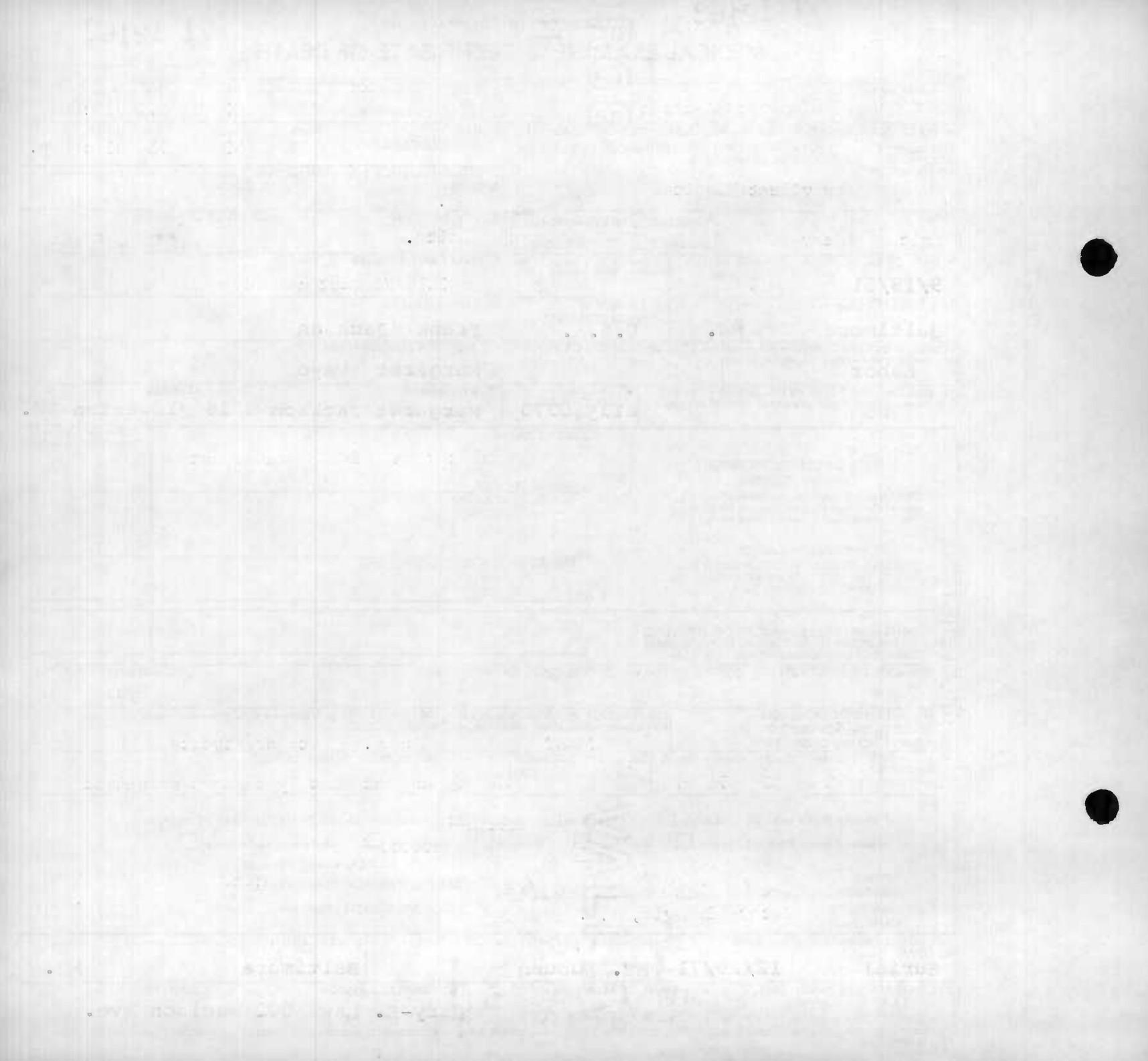
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12162

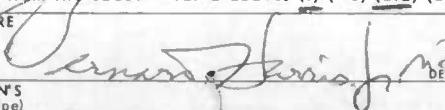
BIRTH NO.

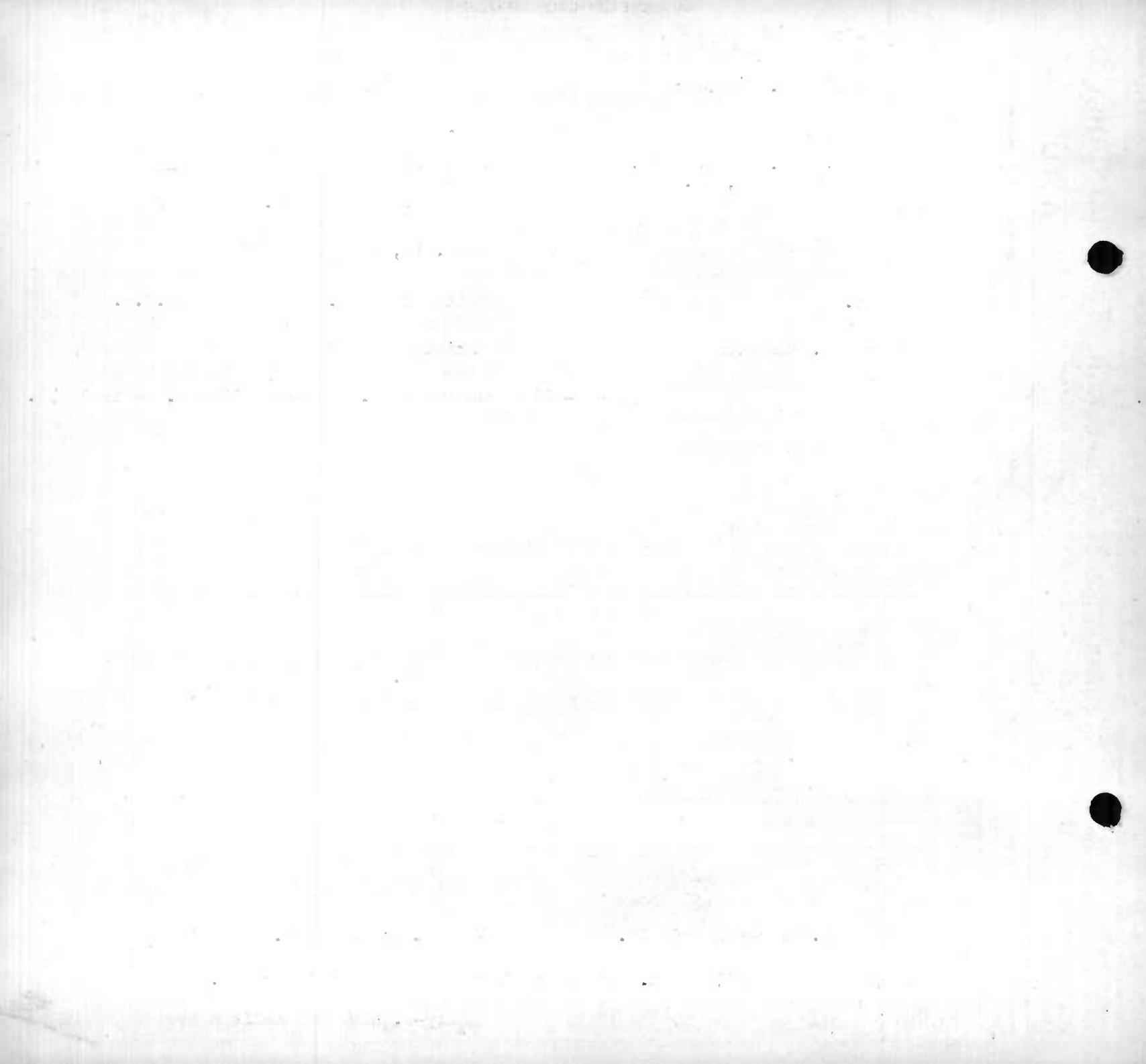
1. NAME OF DECEASED (Type or Print)		Edward Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Estimated <input type="checkbox"/> Month 12	Doy 23	Year 71	Hnur 10:00 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Provident Hospital		3. DATE PRONOUNCED DEAD Month 12 Doy 23 Year 71		Hour 10:00 P.M.	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 9/18/51		10. AGE (In years last birthday) 20	# Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 3816 Flowerton Road
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF Md.	14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Frank Jackson
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213540770	18. INFORMANT Margaret Jackson		ADDRESS Margaret Jackson 3816 Flowerton Rd.		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Gunshot wound of head and chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Penna. & Pitcher Streets			
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 12 23 71 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot by unknown assailant			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/24/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/71		24C. NAME of CEMETERY or CREMATORIUM MT. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1972		25B. NAME OF REGISTRAR Peter Lipkovic, M.D.		25C. FUNERAL DIRECTOR Mary-E. Law		ADDRESS 802 Madison Ave.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12163		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12163	
1. NAME OF DECEASED (Type or Print)		Charles R. Thompson		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				12/ 27/ 71		730 P M	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		1204 N. Central Ave. Baltimore, MD.		A. STATE MD.			
OO				B. COUNTY		1001	
5. SEX M		6. RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1204 N. Central Ave.	
13. FATHER'S NAME Oliver J. Thompson		14. MOTHER'S MAIDEN NAME Arista Jones		B. DATE OF BIRTH Aug. 18, 94		9. AGE (In years lost birthday) 77 If Under 1 Yr. Months: Days: Hours: Min:	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-1513		11. BIRTHPLACE (State or foreign country) Baltimore MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. I 62.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT Genevieve M. Thompson		ADDRESS 1204 N. Central AVE.	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION OO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ to _____, and that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> <u>not</u> view the body after death.							
23A. SIGNATURE 		23B. DATE SIGNED 12/30/71		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) Dr. Bernard Harris JR.		23D. ADDRESS 1200 N. McCulloh st.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/71		24C. NAME OF CEMETERY or CREMATORIUM Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) Baltimore MD. (State)	
25A. DATE REC'D BY HEALTH DEP. JAN 3 1972		25B. NAME OF REGISTRAR Robert J. O'Donnell		25C. FUNERAL DIRECTOR Mary-E. Law		ADDRESS 802 Madison Ave	

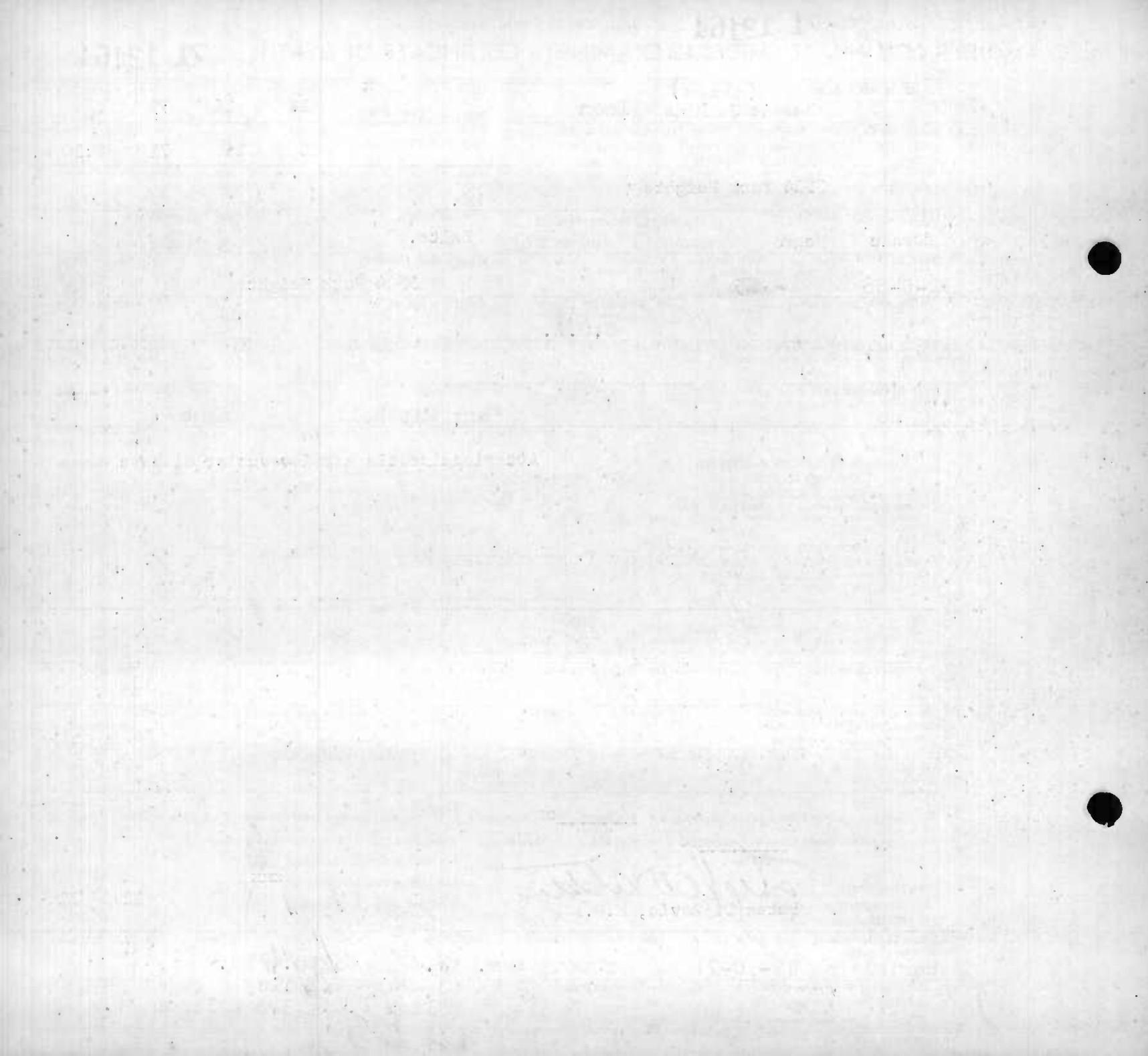


J-525

1  
W-425 71 12164 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12164

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		(Alice) Bessie Jenkins Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 26 Year 71 Hour M. Estimated <input type="checkbox"/>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  OO		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  3524 Park Heights		3. DATE PRONOUNCED DEAD Month 12 Day 26 Year 71 Hour 8:30 a.m.
6. SEX female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-5-86		10. AGE (In years lost birthday) 85	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 3524 Park Heights
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	18. INFORMANT Mary Mitchell	ADDRESS same
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
20A. MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21. AUTOPSY? (Yes or No) no
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Actual Signature EXAMINER'S NAME (Type)  Peter Lipkovic, M.D.		and that on this basis, death in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		DATE SIGNED 12/26/71
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Bailey ADDRESS Kelson F.H. 1348 Calhoun St.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-324 71 12165		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12165
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MITCHELL, THOMAS		2. DATE AND HOUR OF DEATH 12/12/71 at 1820 p.m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE		
5. SEX M 6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-79 9. AGE (in years last birthday) 92 If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) JAMAICA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MARGUERITE Brown 2114 Division St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Congestive Cardiac Failure  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: With probable pulmonary infarction		ADDRESS  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12/11/71 to 12/28/71 that (I) (we) last saw the deceased alive on 12/28/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED
23A. SIGNATURE Anjana Doshi M.D.		23C. PHYSICIAN'S NAME (Type) ANJANA Doshi M.D.		23D. ADDRESS DEGREE
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Bailey M.D.		24D. LOCATION BALTO. Md'
				25C. FUNERAL DIRECTOR V. BAILEY
				ADDRESS 1348 Chelton St.

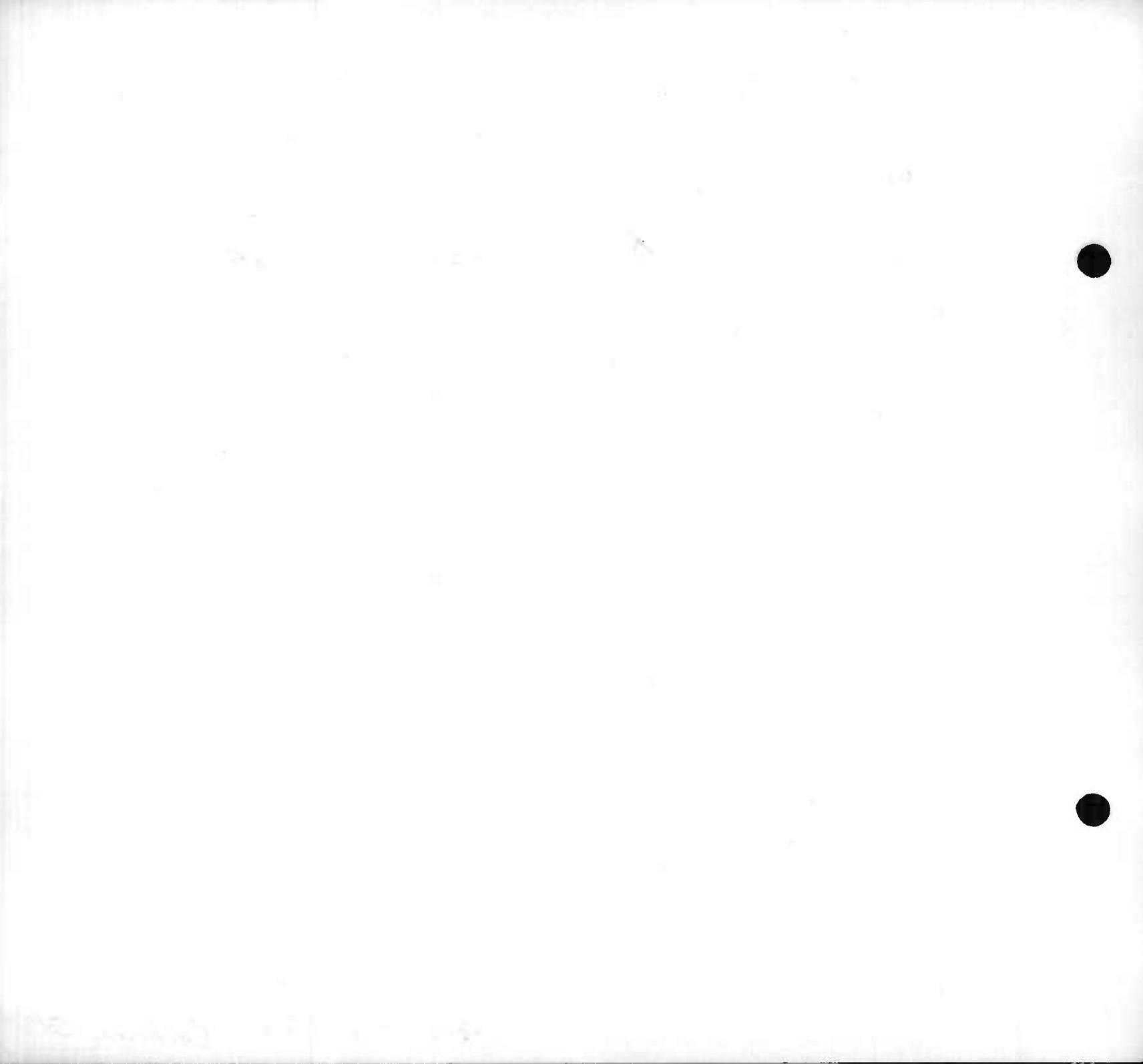
11/8/71 Adm.

Had been in a number  
of institutions prior  
to this.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12166	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	71 12166				
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH								
THOMAS H. DUNAWAY		2. DATE AND HOUR OF DEATH								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)								
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE	B. COUNTY					
UNIV. Md. Hosp.				605 W. LEXINGTON ST 402						
5. SEX		6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.
M		B		6-8-86		85				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY		
MINISTER						VA.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
THOMAS Dunaway		ADELIENE Conway								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
YES				ROBERTA DUNAWAY		SAME				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CARDIO-RESPIRATORY FAILURE				48 HRS.				
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		BRAIN STEM COMPRESSION								
II		(B) DUE TO, OR AS A CONSEQUENCE OF:								
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) INTRATEMP. LOBE HEMATOMA								
MEDICAL CERTIFICATION		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
		11/27/71	Temp. lobe hematoma							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)						
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from _____		12/27	19 71	to	12/28	19 71				
that (I) (we) last saw the deceased alive on _____										
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE		JOSEPH SOLIMAN M.D.				Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		JOSEPH SOLIMAN M.D.				23D. ADDRESS		UNIV Md. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORIAL	24D. LOCATION (City, town, or county)	(State)					
Burial		1-4-72	Arbutus Mem Pk.	Bethel, Md.						
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS						
JAN 3 1972		Robert E. Talley, Jr.	V. Bradley	1810a St. N. 1348 Calhoun St.						



71 12167

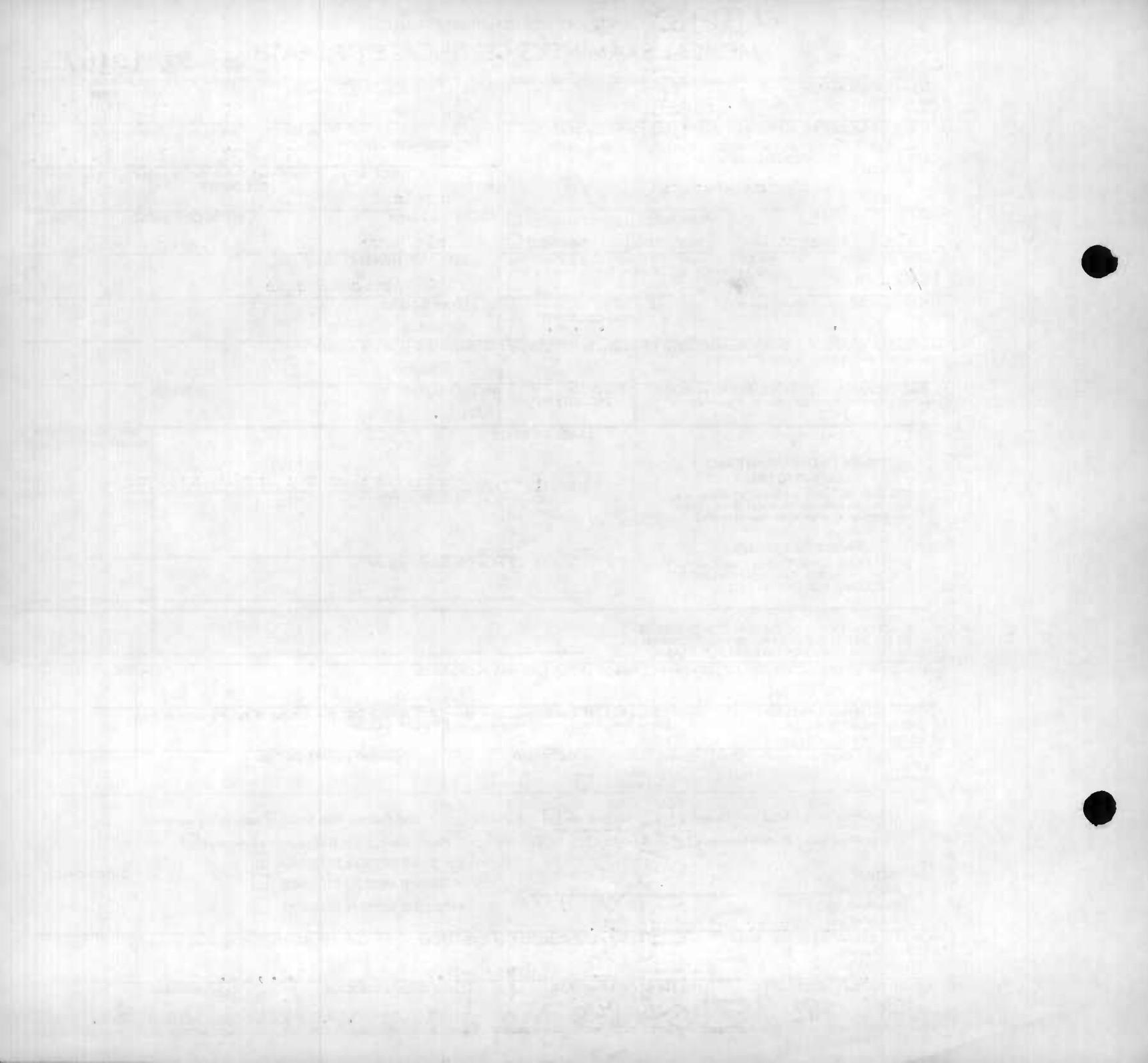
BALTIMORE CITY HEALTH DEPARTMENT

G-650  
BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12167

1. NAME OF DECEASED (Type or Print)		John W. Green		2. DATE OF DEATH Estimated <input checked="" type="checkbox"/> <input type="checkbox"/> 12 27 71	Month Day Year Hour 12:45 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>				3. DATE PRONOUNCED DEAD Month 12 27 71	Day Year Hour 12:45 P.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/22/94		10. AGE (in years at birthday) 77	If Under 8 Yrs. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 2946 Arunah Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Annie Morrall	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		17. SOCIAL SECURITY NO.		18. INFORMANT Robt. Green	
19. <i>412-9</i>		CAUSE OF DEATH		ADDRESS same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT m. WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23.		<p>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion  resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED 12-28-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	24C. NAME of CEMETERY or CREMATORIUM Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun St.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536		71 12168	BALTIMORE CITY HEALTH DEPARTMENT		71 12168
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. _____	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <del>7-15-71</del> 12-27-71 1 7:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u> 6. RACE <u>Ne</u>		E. STREET AND NUMBER <u>3019 Poplar Avenue</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>07-1895</u> 9. AGE (in years lost birthday) <u>75</u> If Under 1 Yr. Months: Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Henderson</u>		10B. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Wooden</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-2041</u>			
17. INFORMANT <u>mrs Marlene Scimyner</u>		18. CAUSE OF DEATH <u>Carcinomatosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Bladder, Urine</u>			
		(C) <u>Heart Disease, Arterial</u>			
II MATERIAL CERTIFICATION 19A. DATE OF OPERATION <u>12-6</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? <u>None</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Dec 19 1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>1971</u> to <u>Dec 19 1971</u> that <u>(I)</u> (we) last saw the deceased alive on <u>Dec 19 1971</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did) (did not) view the body after death.</u>					
23A. SIGNATURE <u>G. Kingdon MD</u>		23B. DATE SIGNED <u>12/27/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>G. KINGDON MD</u>		23D. ADDRESS <u>848 Henlopen Ave Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL, (Specify) <u>Burial</u> 24B. DATE <u>12-30-71</u> 24C. NAME OF CEMETERY OR CREMATORIAL <u>Arbutus Monk</u> 24D. LOCATION (City, town, or county) <u>Baltimore Md.</u> (State) <u>Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u> 25B. NAME OF REGISTRAR <u>Robert E. Kelley, Jr.</u> 25C. FUNERAL DIRECTOR <u>V. Baileen F. H. Kelso</u> ADDRESS <u>1348 Calhoun St.</u>					



BIRTH NO.

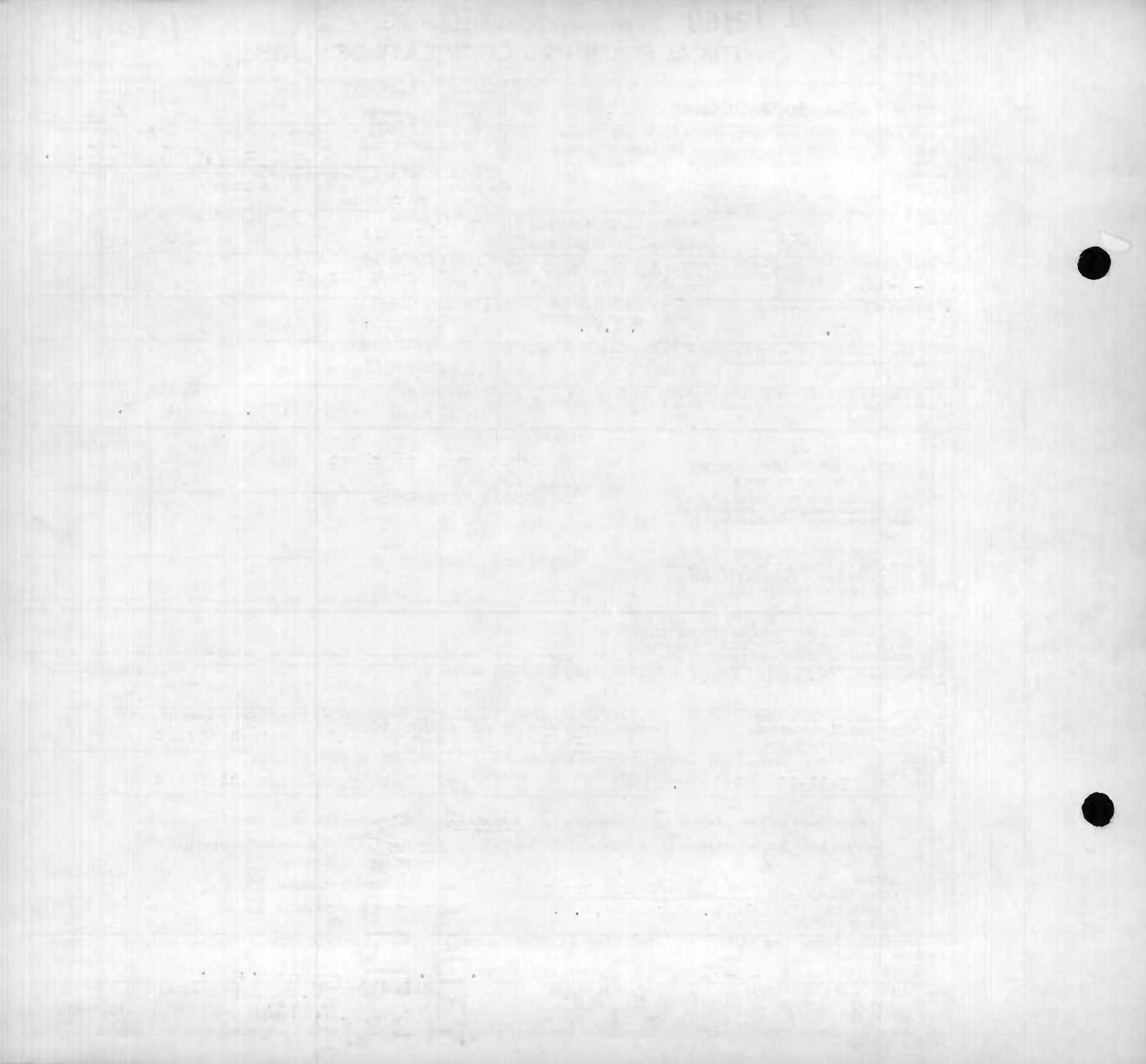
71 12169

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12169

1. NAME OF DECEASED (Type or Print) <b>Theodore Anthony Alston</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month _____ Day _____ Year _____ Hnur _____ Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-6-46	10. AGE (in years last birthday) 25	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF U.S.A.	13. FATHER'S NAME <b>Theodore Alston</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO.	15. MOTHER'S MAIDEN NAME helma King	
19. E 965X	CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	ADDRESS 1041 N. Mount St.	
MEDICAL CERTIFICATION	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
	(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 12	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1000 Block Whatcoat Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-11-71 11:10 P. m.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23.  I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12/29/71	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)  <i>Ronald N. Kornblum</i> Ronald N. Kornblum, M.D.	M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-4-72	24C. NAME of CEMETERY or CREMATORIAL Arbutus Mem. Pk.	24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972	25B. NAME OF REGISTRAR <i>J. Wilson, M.D.</i>	25C. FUNERAL DIRECTOR Bailey	ADDRESS Kelson F.H. 1848 Calhoun Street



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-263 71 12170		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12170	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/31/71 6 10 M			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  90 Belair Nursing Home.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 1001			
FULL NAME OF HOSPITAL OR INSTITUTION  90		C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1012 E. 1 Biddle St.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F. 6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. DATE OF BIRTH Aug. 10, 95 9. AGE (in years last birthday) 76 II Under 1 Yrs. Months: Days Hours Min.			
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina 12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Alison Lynch		14. MOTHER'S MAIDEN NAME Adeline Mills ADDRESS Sadie Taylor - 1012 E. Biddle St.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) SYSTEMIC SCLEROSIS; RHEUMATOID ARTHRITIS ESOPHAGEAL STRicture; CATARACTS			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 9/21/71 to 12/31/71 that (I) (we) last saw the deceased alive on 12/30/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/31/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 1-4-72		24C. NAME OF CEMETERY or CREMATORIAL	
25A. DATE REC'D BY HEALTH DEPT JAN 3 1972		25B. NAME OF REC'D Dr. E. Gabay, M.D.		24D. LOCATION (City, town, or county) Enfield, N. Carolina ADDRESS	
				25C. FUNERAL DIRECTOR Bruce J. Clicken - 1129 N. Carolina	



B-260

BALTIMORE CITY HEALTH DEPARTMENT

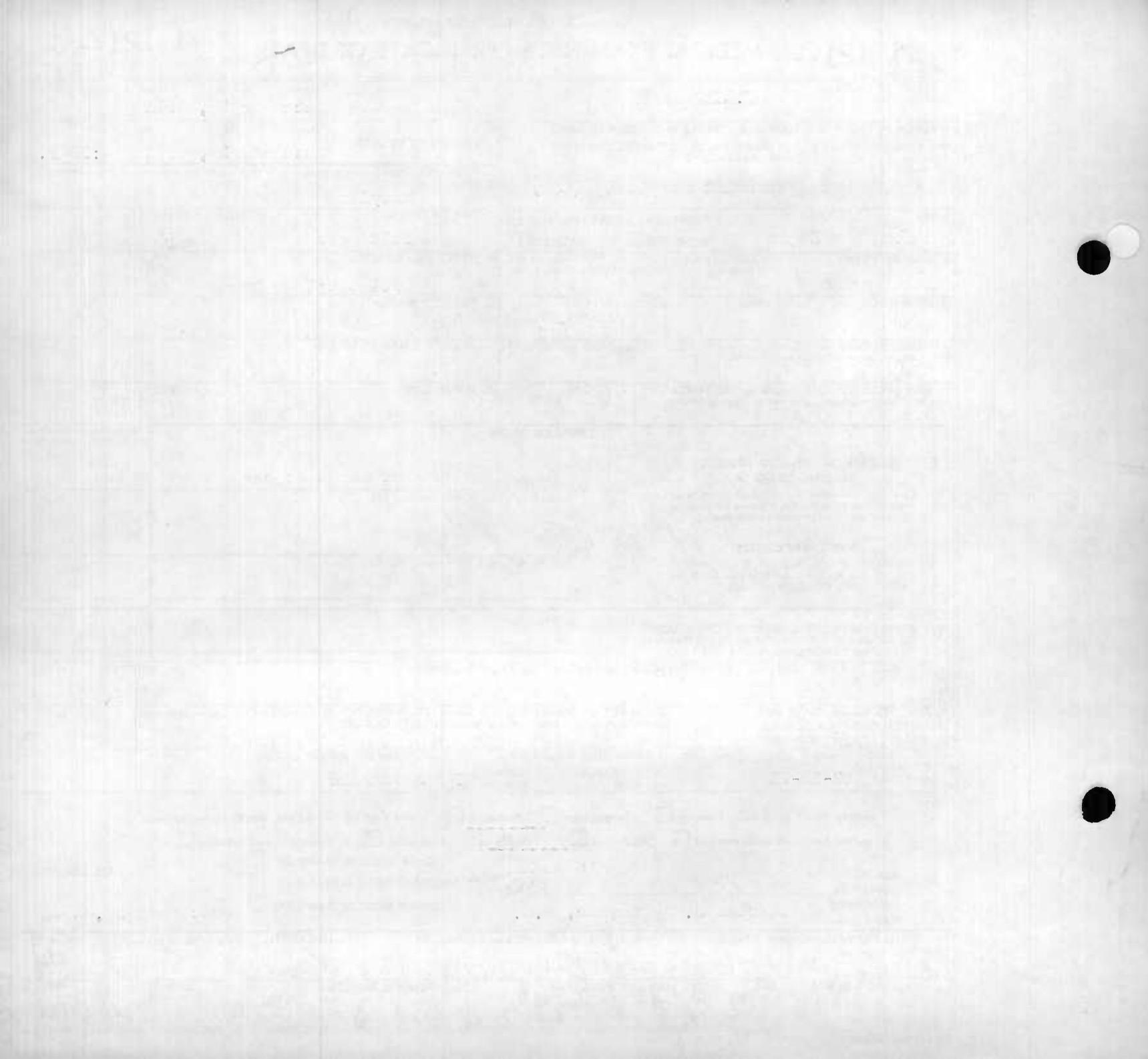
71 12171

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12171  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		WILLIE BAKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month December 29, 1971 Estimated <input type="checkbox"/> Day Year 1971 Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month December 29, 1971 Day 4:35 P.M. Year		
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 5-5-17		10. AGE (In years lost birthday) 54	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 4901 Catalpha Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		14B. KIND OF BUSINESS OR INDUSTRY W.W.II	15. MOTHER'S MAIDEN NAME Mit Baker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) Yes		17. SOCIAL SECURITY NO.	18. INFORMANT Fairmean Baker-4701 Catalpha Rd, ADDRESS	
19. E 955 X 1		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Home	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4901 Catalpha Road	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-29-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Shot self	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		and that on this basis, death in my opinion		
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-72	24C. NAME OF CEMETERY or CREMATORIUM Md. National Mem. Pk.	24D. LOCATION (City, town, or county) Laurel
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR P.B. E. Barber, M.D.	25C. FUNERAL DIRECTOR Frank J. Clarkson-112971, Carolina	DATE SIGNED December 30, 1971
VS 151-REV. 1/1/68 N 854.1				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 12172

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 71 12172

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SIMMONS

JUANITA

2. DATE AND HOUR OF DEATH

12-31-71

11.00 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

905

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES  NO

E. STREET AND NUMBER

1415 Montpelier St. Baltimore MD 21218

5. SEX

Female

6. RACE

C

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

Oct. 17 1930

9. AGE (in years  
last birthday)

41 yr

If Under 1 Yr.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Goodman Construction

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Archie McLean

14. MOTHER'S MAIDEN NAME

Victoria Oden

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 430.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

General Haemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension?

(C)

Hyperacute Berry aneurysm

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

O

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

No

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work

Not While At Work

22. I certify that (I) (this hospital) attended the deceased from 12-26-1971 to 12-31-1971  
that (I) (we) last saw the deceased alive on 12-31-1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Abdul Majid Memon M.D.  
(Type)

DEGREE

Attending Phys.

Med. Director

Staff Phys.

DATE SIGNED

1-1-72

23C. PHYSICIAN'S  
NAME (Type)

ABDUL MAJID MEMON M.D.

DEGREE

Cemetery

24C. NAME OF CEMETERY OR CREMATORIAL

LOCATION  
(City, town, or county)  
(State)

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

1-3-72

MT. Calvary Cemetery

24D. LOCATION

(City, town, or county)  
(State)

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 3 1972

Robert E. Barber, M.D.

25B. NAME OF REGISTRAR

00000

25C. FUNERAL DIRECTOR

00000

ADDRESS

26. ADDRESS

VS 150-REV. 1/1/68



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630		71 12173	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12173
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/28/71 17:40 P.M.			
1. NAME OF DECEASED (Type or Print) <i>John S. Ward</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland & COUNTY 2102			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  University of Maryland Hospital <i>38</i>		C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1271 Washington Boulevard		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/01	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Yard Master</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B&amp;O R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>George F. Ward</i>		14. MOTHER'S MAIDEN NAME <i>Maude D. McCauley</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-05-5188A</i>		17. INFORMANT Anna M. Ward 1271 Washington Blvd.	
18. <i>410-7</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <i>Cardiogenic Shock</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stealing the UNDERLYING CONDITION last.		(B) <i>Acute MI</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>CVA</i>		(C)		<i>10 days</i>	
19A. DATE OF OPERATION <i>12/28/71</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>(If In Baltimore City, give exact location)</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) <i>While At Work</i>		21C. WHERE DID INJURY OCCUR? <i>Not While At Work</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>(APPROX.)</i>		21E. INJURY OCCURRED <i>While At Work</i>		21F. HOW DID INJURY OCCUR? <i>Not While At Work</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 20</i> to <i>Dec 28</i> 1971 that (I) (we) last saw the deceased alive on <i>Dec 28</i> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard A. Tomasulo M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/28/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard Tomasulo</i>		23D. ADDRESS <i>Univ. of Maryland Hosp., Balt., Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/71</i>		24C. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Mem. Park</i>	
24D. LOCATION (City, town, or county) <i>Anne Arundel Co., Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Ruth B. J. Bay Jr.</i>		25C. FUNERAL DIRECTOR <i>Walter's Funeral Home Pratt &amp; Stricker</i>	
				ADDRESS <i>Streets 21225</i>	
VS 150-REV. 1/1/68					



## BALTIMORE CITY HEALTH DEPARTMENT

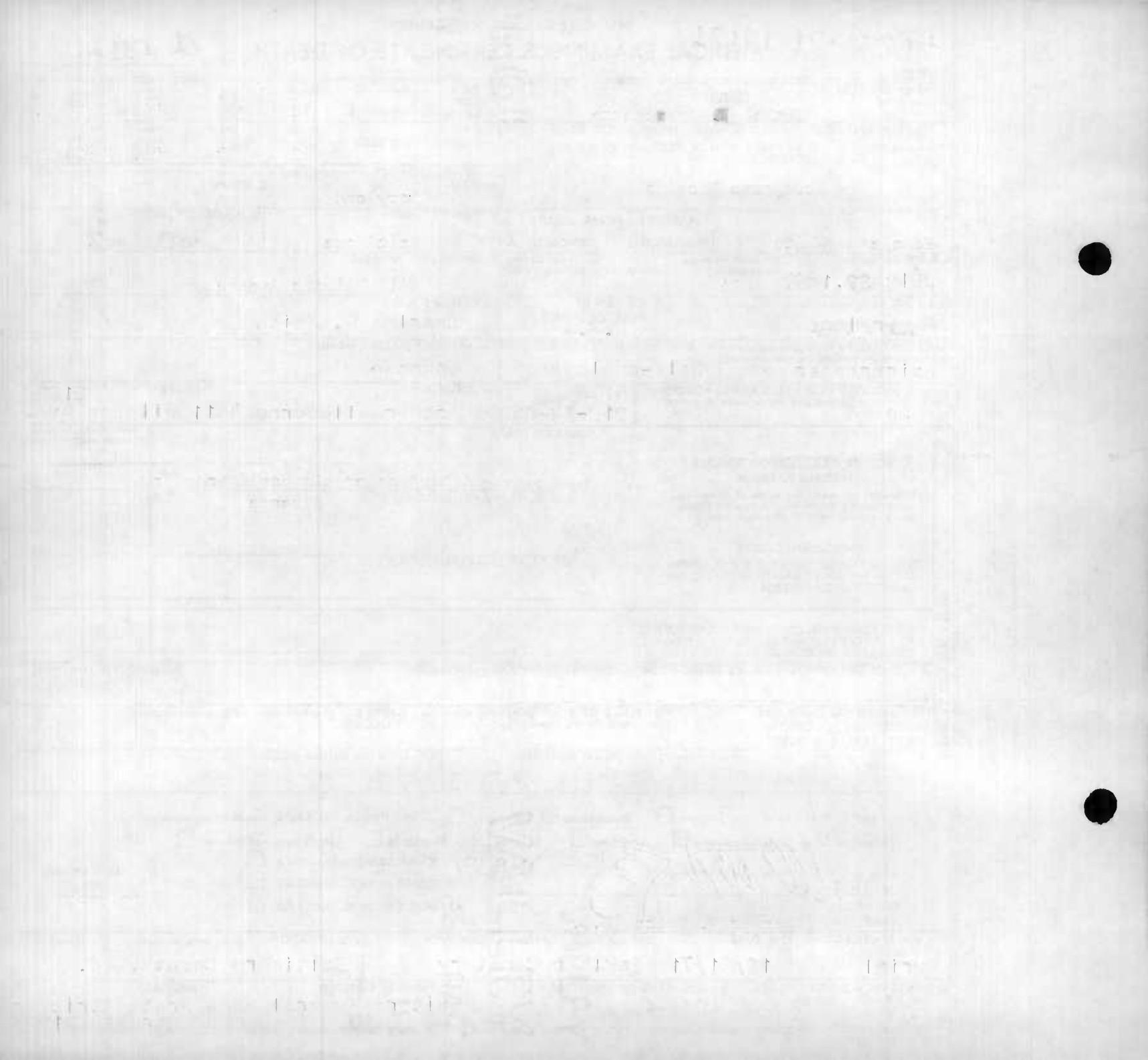
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12174

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Mae Ethel Frenchette		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Doy 27	Year 71	Hour 7:30 P.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD	Estimated <input type="checkbox"/> Month	Doy 27	Year 71	Hour		
		St. Agnes Hospital						7:30 P.M.		
6. SEX	7. RACE	8. MARRIED	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	C. CITY OR TOWN	D. INSIDE CITY LIMITS?					
Female	White	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	Baltimore	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>				
9. DATE OF BIRTH	10. AGE (In years (last birthday))	11. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER							
July 22, 1897	74		4411 Wilkins Avenue							
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	FATHER'S NAME	15. MOTHER'S MAIDEN NAME							
Maryland	U.S.A.	Charles R. Smith	Unknown							
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.	18. INFORMANT	ADDRESS
Hairdresser		Self-employed		No				219-32-0620A	Arthur Kilbourne	21229 4411 Wilkens Ave.
19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)				No		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?						
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?						
23.  I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 12-28-71		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORIUM		24D. LOCATION (City, town, or county) (State)				
Burial		12/31/71		Oaklawn Cemetery		Baltimore County, Md.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS				
JAN 3 1972		Rebek L. Farley, R.D.		Walters Funeral Home		Pratt & Stricker Streets 21223				



60-34-92 djr

T-460  
71 12175BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH X

REG. NO.

71 12175

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		2. DATE AND HOUR OF DEATH 12/27/71 3 <sup>30</sup> a.m. M.	
1. NAME OF DECEASED (Type or Print) <b>Eva Barbara Tyler</b>		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 5300	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Fullerton	
Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE Caucasian		E. STREET AND NUMBER 8900 Belair Rd 21236	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-00	
9. AGE (in years last birthday) 71		10. KIND OF BUSINESS OR INDUSTRY	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry Smearman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-54-1954	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT 4940 Eastern Avenue ADDRESS BCH: RECORDS Baltimore, Maryland 21224	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.	
(A) IMMEDIATE CAUSE Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF:			
(B) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF:		years	
(C) Pernicious anemia		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3:30 a.m. 12/27/71 1971 to 4:30 a.m. 12/27/71 1971 that (I) (we) last saw the deceased alive on 4:00 a.m. 12/27/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michele Codlin, M.D.		23B. DATE SIGNED 12/27/71	
23C. PHYSICIAN'S NAME (Type) Michele Codlin		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland Baltimore City Hospital 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71	
24C. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Parker, Jr.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	
VS 150-REV. 1/1/68			

12 miles west of town of Eureka

2000 ft.

2 miles west of town of Eureka

2000 ft.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-435		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12176	
BIRTH NO. 71 12176		1. NAME OF DECEASED KERNAL M. HELTON		2. DATE AND HOUR OF DEATH DECEMBER 27, 1971 12:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> 4940 Eastern Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk		5. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5800	
6. SEX Male 7. RACE Caucasian 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 4-29-10 10. AGE (in years last birthday) 61		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bethlehem Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Benjamin J. Helton		14. MOTHER'S MAIDEN NAME Frances Disney	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 405-03-8238		17. INFORMANT 4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland		ADDRESS 21222	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death)		M.D. CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Myocardial Infarction 1/2 Hour			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) EXP ASSIST. MEDICAL EXAMINER (B) DUE TO, OR AS A CONSEQUENCE OF: C					
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II(A)							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bridge, etc.)		21C. WHERE DID INJURY OCCUR? (In Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 27, 1963 to December 27, 1971 that (I) (we) last saw the deceased alive on December 27, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James Yeung, M.D.		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) James Yeung, M.D.		23D. ADDRESS Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore Md 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORIAL Bel Air Memorial Gardens		24D. LOCATION Bel Air, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Taylor Jr.		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	
VS 150-REV. 1/1/68							

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12177		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 12177	
1. NAME OF DECEASED (Type or Print)		NORMAN MCKINNEY Norman McKinney		2. DATE AND HOUR OF DEATH 12/30/71 145 PM		12/30/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5 300	
5. RACE		(If not in hospital or institution, give street address or location) Caucasian		6. SEX Male		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired - Supt. of Apartments		8. DATE OF BIRTH 8-25-03		9. AGE (in years last birthday) 68	
13. FATHER'S NAME Charlie McKinney		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 246-14-3845A		17. INFORMANT BCH-Records		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. <b>410.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF: Brain Damage 2° Anoxia				11 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <del>Retired</del> By Atrial Fibrillation		(B) DUE TO, OR AS A CONSEQUENCE OF: (c) 2° Cardiac Arrest 2° Paroxysmal Acute Myocardial Dysfunction				11 days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>this hospital</del> attended the deceased from 12-19-71 19 to 12-30-71 19 that (I) <del>saw</del> last saw the deceased alive on 12-29-71 19 and that In (my) <del>opinion</del> death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <del>not</del> view the body after death.							
23A. SIGNATURE <i>W. L. Ramseur</i>		MD DEGREE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/30/71	
23C. PHYSICIAN'S NAME (Type) W. L. Ramseur MD		23D. ADDRESS 4940 Eastern Avenue 21224		Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 1/2/72		24C. NAME OF CEMETERY or CREMATORIUM Pittman Cemetery		24D. LOCATION (City, town, or county) Spruce Pine, Mitchell Co., N. C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR <i>John J. Duda</i>		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

negative material

negative material

negative material

negative material

negative material

negative material

## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			REG. NO. 71 12178	
BIRTH NO. H-400		71 12178			+ REG. NO. 71 12178	
1. NAME OF DECEASED (Type or Print) Hall, James Leroy		2. DATE AND HOUR OF DEATH 12/28/71 3:35 a.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY HOWARD County				
FULL NAME OF HOSPITAL OR INSTITUTION  ADDRESS OR LOCATION)		C. CITY OR TOWN COLUMBIA			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5433 WOLF RIVER LANE b300						
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/92	9. AGE (in years lost birthday) 79	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MD. CASUALTY		10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME RICHARD L. HALL		14. MOTHER'S MAIDEN NAME CARTER, Emma			12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-5952			17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  Small intestinal obstruction  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Abdominal adhesions  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A),						
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 27, 1971 to Dec 28, 1971 that (I) (we) last saw the deceased alive on Dec 28, 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE THIN THITIVARANA		M.D. DEGREE	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED Dec 28, 1971		
23C. PHYSICIAN'S NAME (Type) THIN THITIVARANA		M.D. DEGREE	23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71	24C. NAME of CEMETERY or CREMATORIAL ARBITUS MEMORIAL PARK	24D. LOCATION BALTIMORE, MARYLAND	(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR John E. Fisher, M.D.	25C. FUNERAL DIRECTOR Arlington & Phillips Funeral Home	25D. ADDRESS 1729 N. Monroe St.		
VS 150-REV. 1/1/68						



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		71 12179	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12179	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 12-30-71 9-19 P.M.		
1. NAME OF DECEASED (Type or Print)		<i>MASSEY, Gabriel</i>		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE Maryland B. COUNTY 1504		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  <i>42</i> Sinai Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2009 McKean Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1911	9. AGE (In years last birthday) 60	II Under 1 Yrs. Months: Days	II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		
13. FATHER'S NAME  <i>Hidia Massey</i>		14. MOTHER'S MAIDEN NAME  <i>Janie Bush</i>		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 246-18-7975		17. INFORMANT  Edna Massey 2009 McKean AVXnue ADDRESS		
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slating the UNDERLYING CONDITION lost.						
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Diabetic Keto Acidosis</i> 3 days.						
(B) DUE TO, OR AS A CONSEQUENCE OF:  <i>Severe infection, possibly Septicemia</i> 3 days.						
(C) <i>Diabetes Mellitus</i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  <i>Pre-renal failure</i> 3 days.						
19A. MEDICAL CERTIFICATION O		19B. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>12-29</u> to <u>12-30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12-30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.						
23A. SIGNATURE  <i>Mansour</i>		M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-30-71</u>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS  <i>S. H. at Baltimore</i>		ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-71		24C. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Park		24D. LOCATION (City, town, or county) Baltimore, Maryland (State)
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 8 1972</u>		25B. NAME OF REGISTRAR <u>Raymond</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 N. Monroe Street</u>		
VS 150-REV. 1/1/68						



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12180	
BIRTH NO. 71 12180					
1. NAME OF DECEASED (Type or Print) JOHNSON E. ROSALIND		2. DATE AND HOUR OF DEATH 12/25/71 850 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  SINAI HOSPITAL 42 OF BALTO		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD BALTO B. COUNTY BALTO C. CITY OR TOWN BALTO E. STREET AND NUMBER 5441 PAICE AVE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX FEA, RACE NEGRO 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIDE PROVIDENT HOSP		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8/13/50 9. AGE (in years last birthday) 21 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Raymond Johnson		14. MOTHER'S MAIDEN NAME Eva Palmer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-58-8540		17. INFORMANT Raymond Johnson 2708 Chelsea ADDRESS	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebral vascular accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/13/71	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/24/71 to 12/25/71 that (I) (we) last saw the deceased alive on 12/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DAVID GLASER, M.D.		M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/25/71	
23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D.		23D. ADDRESS SINAI HOSP. OF BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY OR CREMATORIAL New Cathedral	
				24D. LOCATION (City, town, or county) Baltimur Maryland	
				25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972	
				25B. NAME OF REGISTRAR	
				25C. FUNERAL DIRECTOR	
				ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

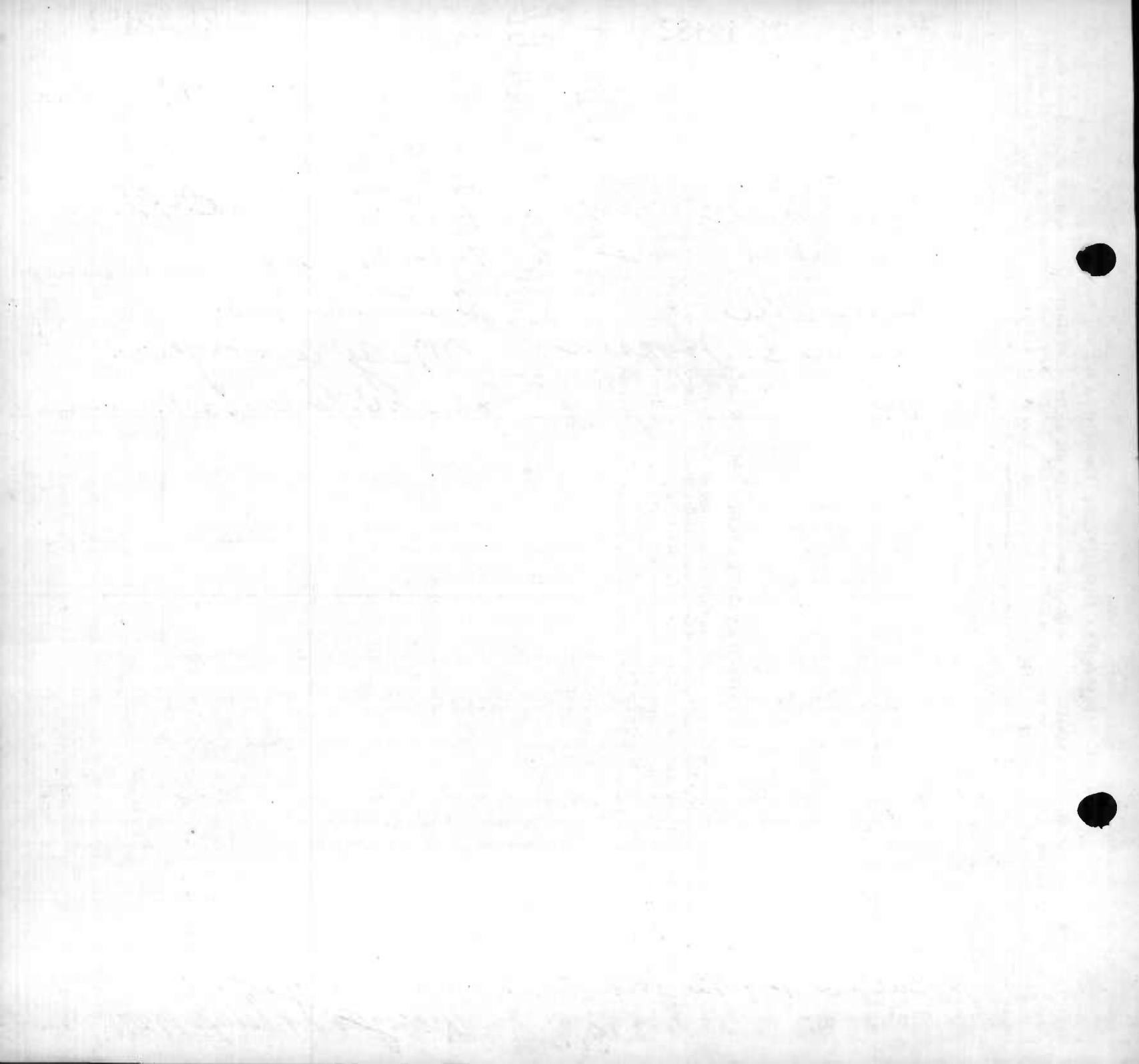
5-250 BIRTH NO.		71 12181		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12181	
1. NAME OF DECEASED (Type or Print)		Shirley V. JACKSON		2. DATE AND HOUR OF DEATH 12-25-71		11 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION  33 Johns Hopkins Hospital		C. CITY OR TOWN 2641 HUIRON ST		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2543	
E. STREET AND NUMBER							
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/07/37	9. AGE (in years last birthday) 34	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles, John		14. MOTHER'S MAIDEN NAME CLINKSCALES, ELIZABETH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-32-8407		17. INFORMANT Robert Jackson Same		ADDRESS	
18. <del>014</del> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPOVOLEMIA + Shock				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF: GASTROINTESTINAL Hemorrhage							
(C) ? TUBERCULOSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). SARCOIDOSIS							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If In Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from... 12-1- 1971 to 12-25-1971 that (I) (we) last saw the deceased alive on 12-25- 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Neil R Miller, MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-25-71			
23C. PHYSICIAN'S NAME (Type) NEIL R MILLER, MD		23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORIAL Mt. Calvary		24D. LOCATION (City, town, or county) A.P.C. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Jackson, MD		25C. FUNERAL DIRECTOR Johns Hopkins Hospital		ADDRESS 1727 N. Moore Street	
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-200 71 12182		CERTIFICATE OF DEATH		71 12182	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Grace Evelyn Hayes		12-29-1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>OB 4013 Calbarne Rd.</i>		Maryland		1608	
ADDRESS OR LOCATION <i>Baltimore, Maryland</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>7-1-1911</i>		9. AGE (in years lost birthday) <i>60</i>		If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>John C. Hynson</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Taylor</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John F.H. Hayes 630 N. Avondale St.</i>	
18. <i>571.9</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1wk.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Mycocardial Failure</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Emphysema &amp; Liver &amp; Ascites</i> DUE TO, OR AS A CONSEQUENCE OF:			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-28</i> to <i>12-29</i> , that (I) (we) last saw the deceased alive on <i>12-29</i> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Franklin Phillips MD</i>		Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/31/71</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>5581 Maryland Battle Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-4-72</i>		24C. NAME OF CEMETERY or CREMATORIAL <i>Archutus Mem. St. Baltimore</i>	
24D. LOCATION (City, town, or county) <i>Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 3 1972</i>		25B. NAME OF REGISTRAR <i>Grace E. Phillips</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Washington St. Phillips 1727 N. Maryland</i>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>G-635</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12183</u>	
1. NAME OF DECEASED (Type or Print) <u>H Dent</u> <u>H arold Gordon</u>		2. DATE AND HOUR OF DEATH <u>12-29-71</u> <u>3:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>37</u> Mercy Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1502</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-16-19</u>		9. AGE (In years lost birthday) <u>52</u>		11 Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Commercial Credit</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>William Dent</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Brooks</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. Citizen</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>215-12-8587</u>		17. INFORMANT <u>BESSIE DENT</u>	
18. <u>402X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		ADDRESS <u>1634 N. APPLETON STREET</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>with cerebral Hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) <u>Pressure Intracranial Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>7 days (?)</u>			
(C) <u>Hypertensive Heart Disease</u> <u>Aspiration Pneumonia (?)</u> <u>2 days</u>					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <u>12/29/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?			
		22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> to <u>12/29</u> 19 <u>71</u> and that (we) last saw the deceased alive on <u>12/29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
		23A. SIGNATURE <u>Edmunds. Rawls</u>		23B. DATE SIGNED <u>12/29/71</u>	
		23C. PHYSICIAN'S NAME (Type)		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME OF CEMETERY or CREMATORIUM <u>MD NATIONAL MEMORIAL PARK</u>		24D. LOCATION (City, town, or county) <u>LAUREL, MARYLAND</u> (State) <u>MARYLAND</u>	
BURIAL <u>1-3-72</u>		25B. NAME OF REGISTRAR <u>Reg. # 300</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips-1727 N. Monroe St-21217</u> ADDRESS <u>JAN 3 1972</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>					

*200*

*100*

*50*

*10*

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

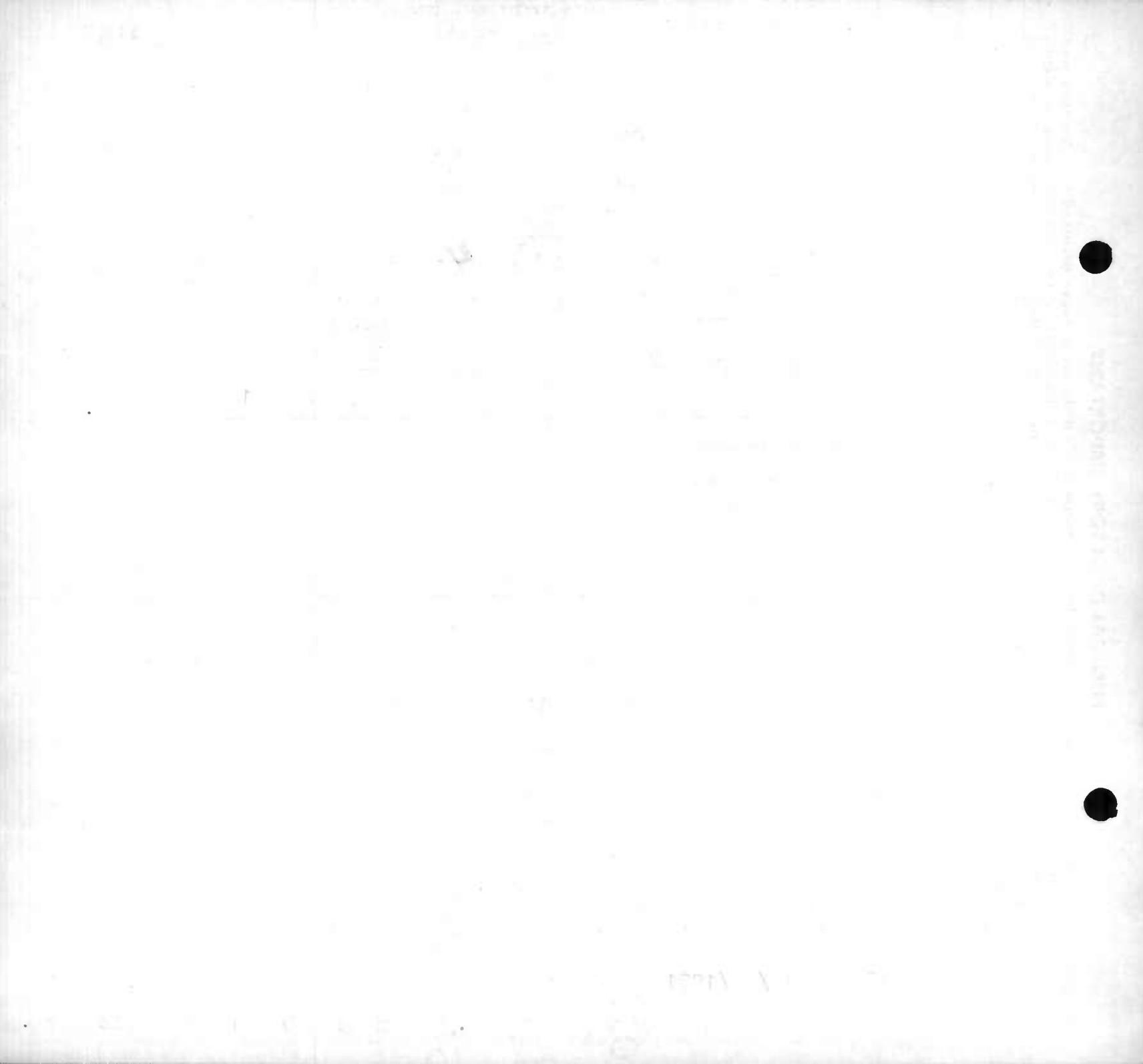
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12184</u>	
1. NAME OF DECEASED (Type or Print)		<u>DRAYTON</u>		2. DATE AND HOUR OF DEATH <u>12-28-71</u> <u>11:00 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1502</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Saint Hospital of Baltimore</i>		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Belvedere Av. at Greenspring</i>		C. CITY OR TOWN <u>Baltimore</u>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>08/03/07</u>		9. AGE (in years lost birthday) <u>64</u>		10. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired from Penna R.R.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. ADDRESS <u>Willie J. Drayton / 1717 N. Monroe St.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Heart attack</i>		19. CAUSE OF DEATH <i>cardiac arrest, failure to respond to pace-maker</i>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Head injury &amp; coma Gary to</i>			
ANTECEDENT CAUSES <i>Unknown</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>probable</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>R. subdural hematoma.</i>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> <u>1971</u> to <u>12/28</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>12/28</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. DATE SIGNED <u>12/28/71</u>	
MEDICAL CERTIFICATION		21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21D. TIME OF INJURY (Month) <u>12</u> (Day) <u>16</u> (Year) <u>71</u> (Hour) <u>at night</u>		21E. INJURY OCCURRED <u>2</u> While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fell in his bathroom</i>	
22A. PHYSICIAN'S NAME (Type) <u>H. LEVEQUE</u>		23D. ADDRESS <u>Saint Hospital of Baltimore</u>		23E. DATE SIGNED <u>12/28/71</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-72</u>		24C. NAME OF CEMETERY or CREMATORIAL <u>M. National Mem. Ch.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Reg. 200</u>		25C. FUNERAL DIRECTOR <u>Delightful Phillips 1727 N. Monroe St.</u>	
VS 150-REV. 1/1/68				ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-656 71 12185		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12185		
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-27-1971 8:00 A.M.				
1. NAME OF DECEASED (Type or Print) WERNER, MARY Christine		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY 903 C. CITY OR TOWN Baltimore MD. E. STREET AND NUMBER 636 E. 36TH STREET Baltimore MD 21218 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-30-88	9. AGE (in years last birthday) 83 If Under 1 Yr. Months 83 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME William SCHAWAB		14. MOTHER'S MAIDEN NAME Rosiana W. GLENZER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		
16. SOCIAL SECURITY NO. 220-46-4849		17. INFORMANT Mrs Charles Birx		18. CAUSE OF DEATH Renal Failure  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:  (C) ARTERIO SCLEROTIC CARDIO V. DISEASE  Pneumonia.		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 12		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. AUTOPSY? (Yes or No) YES	20D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12-25 1971 to 12-27 1971 that (I) (we) last saw the deceased alive on 12-27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Gottlieb		23B. DATE SIGNED 12-27-71				
23C. PHYSICIAN'S NAME (Type) Carlos A. Gottlieb MD		23D. ADDRESS UNION MEMORIAL HOSPITAL MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/1971		24C. NAME OF CEMETERY or CREMATORIUM Oaklawn		24D. LOCATION (City, town, or county) Baltimore County, Maryland (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR John Schwab		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave.



59-55-72 d/jr

E-152 71 12186

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12186

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

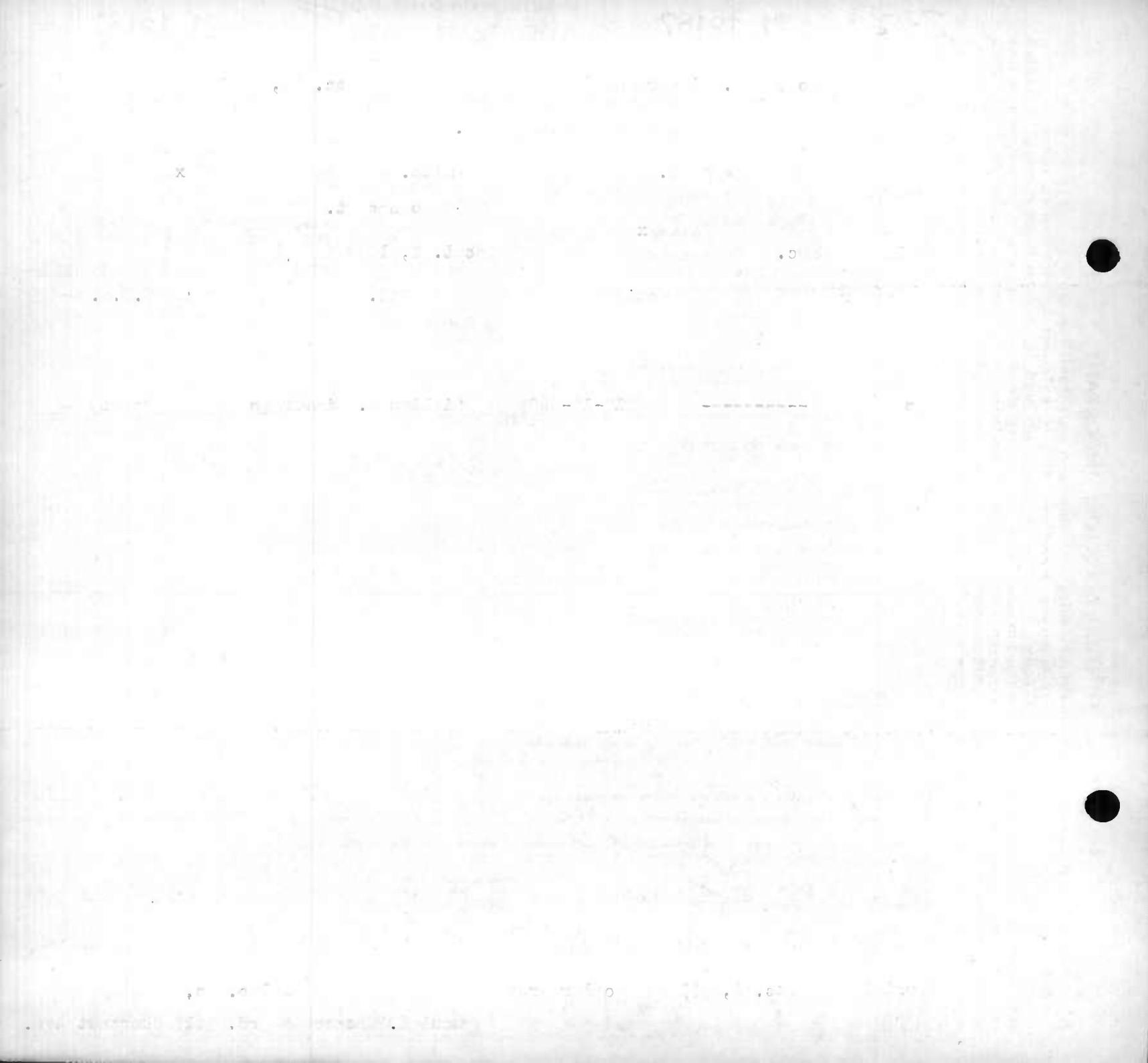
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/27/71	
1. NAME OF DECEASED (Type or Print) EVANS OGDEN A.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE M.D. B. COUNTY Baltimore C. CITY OR TOWN Baltimore E. STREET AND NUMBER 340 S. Macon St. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSP. 4940 Eastern Avenue BALTIMORE, Md. 21224		5. SEX Male 6. RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/24/1800 9. AGE (in years last birthday) 71 If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bread Salesman		10B. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnson Evans		14. MOTHER'S MAIDEN NAME Mary Whitney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH: Records		4940 Eastern Avenue ADDRESS Baltimore, Maryland 21224	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTICEMIA  (B) DUE TO, OR AS A CONSEQUENCE OF: DECUBITUS ULCER  (C) CIRRHOSIS  chronic alcoholism	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71 wk	
19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-9 that (I) (we) last saw the deceased alive on 12-27 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Smit Sines M.D.		23B. DATE SIGNED 12/27/71	
23C. PHYSICIAN'S NAME (Type) SVRAT SINASA		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/71	
24C. NAME OF CEMETERY OR CREMATORIAL American Legion Cemetery		24D. LOCATION (City, town, or county) Crisfield, Somerset, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md. 21817		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12187	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	71 12187	
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH		
Joseph A. Zimmerman					Dec. 29, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  830 Powers St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY /306					
5. SEX Male 6. RACE Caus.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1899	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 217-18-5605	17. INFORMANT Lillian E. Zimmerman	ADDRESS (same)			
18. <i>404 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <i>arteriosclerotic CUR Dis</i> DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C).....					
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 1970 to Dec 29 1971, that (I) (we) last saw the deceased alive on Dec 24 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Edward H. Glassman</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/31/71				
23C. PHYSICIAN'S NAME (Type) EDWARD H. GLASSMAN MD		23D. ADDRESS <i>4037 Falls Rd.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 31, 1971	24C. NAME OF CEMETERY OR CREMATORIAL VEGREE Poplar Grove	24D. LOCATION (City, town, or county) Balto. Co.	(State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1972		25B. NAME OF REGISTRAR Robert E. Talley, Jr.	25C. FUNERAL DIRECTOR Paul E. Chenoweth 3rd.	ADDRESS 3617 Chestnut Ave.			



## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-426  
BIRTH NO.

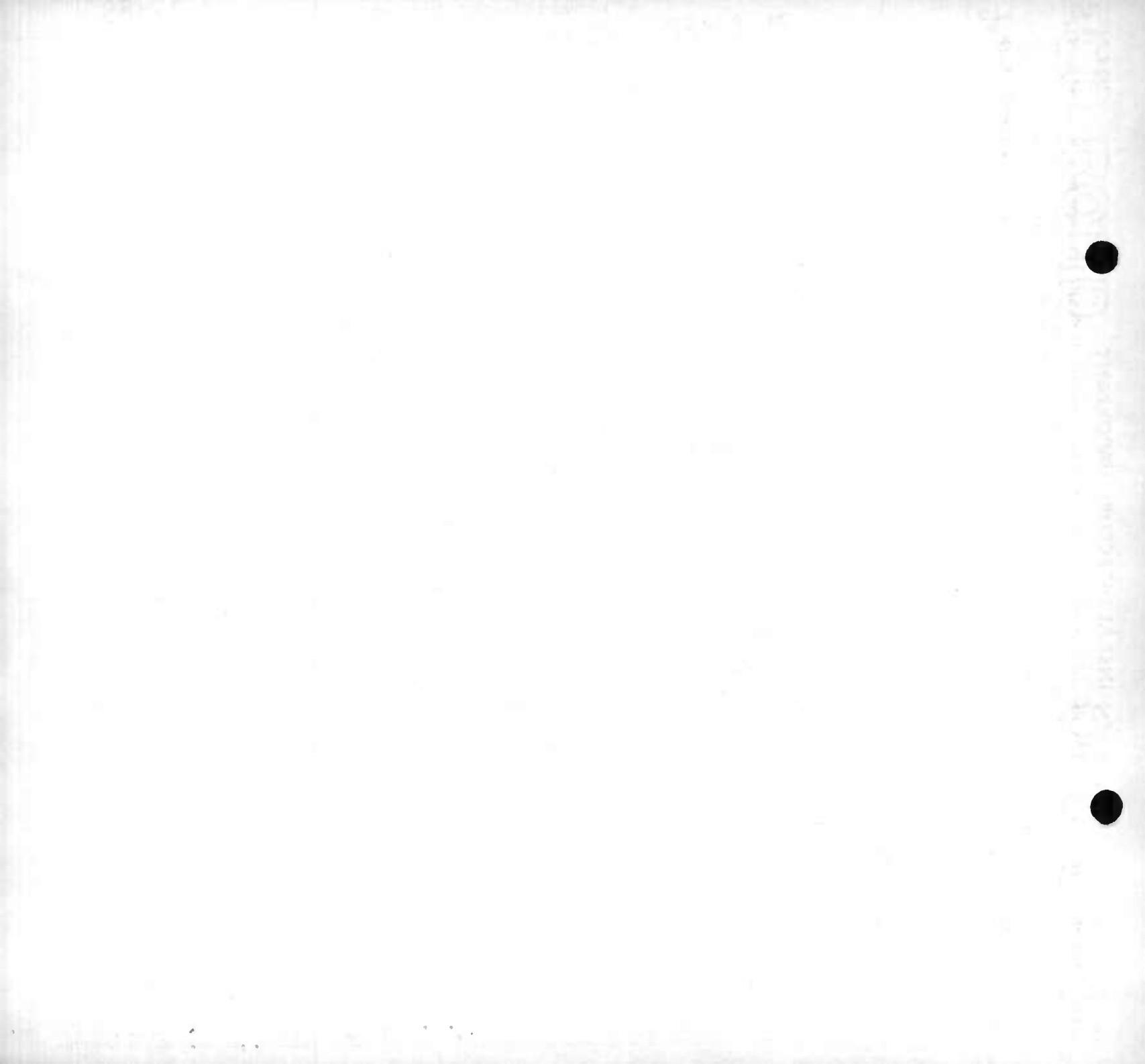
71 12188

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO

71 12188

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
RELEKER CLARA D.		Dec. 30 1971 6 30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)	
44 UNION MEMORIAL HOSPITAL.		Baltimore	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
A. STATE			
Md. CITY			
C. CITY OR TOWN			
D. INSIDE CITY LIMITS?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER			
1522 TUNAW RD. 21218			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W	11-13-80	9. AGE (in years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
HOMEMAKER		OWN HOME	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
EMIL DIPPEL		LOUISA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
18. CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
D		No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 12-11-71 19 to 12-30-71 19 that (I) (we) last saw the deceased alive on 12-30-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
		12-30-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
JAIME PALMER MD		V. Mea. Hosp.	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORIUM	24D. LOCATION
Burial	1/3/72	Greenmount	Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 3 1972		H.W. Jenkins & Sons Co.	4905 York Rd. Balto., Md. 21212



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12189</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <u>12-31-71</u> 5 am M.			
Robert J. Nicholson					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2755</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u>		C. CITY OR TOWN <u>MT. Washington</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1812 SOUTH ROAD</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-1876</u>	9. AGE (in years last birthday) <u>95</u>	If Under 1 Yr. Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR - SELF-EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TYPEWRITER BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>Kent County Md</u>	
13. FATHER'S NAME <u>Robert H. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Lusby</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-30-5040</u>		17. INFORMANT <u>Keswick Records</u>	
18. <u>412.4</u> I		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>cardio vascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Zero</u> <u>episode</u> <u>failure</u> <u>1 wk</u> <u>every</u> <u>4 yr</u>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>New Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>(If in Baltimore City, give exact location)</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>(If in Baltimore City, give exact location)</u>	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1969</u> to <u>31 Dec 1971</u> and that (I) (we) last saw the deceased alive on <u>31 Dec 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold P. Biehl MD</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. HAROLD P. BIEHL</u>		23D. ADDRESS <u>KESWICK HOME</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/3/72</u>		24C. NAME OF CEMETERY OR CREMATORIAL <u>Chester Cemetery</u>	
				24D. LOCATION (City, town, or county) <u>Chestertown</u> (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 3 1972</u>		25B. NAME OF REGISTRAR <u>Wadey - E.D. 0 0 0</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd.</u> <u>Baltimore, Md. 21212</u>	

1990-1991

1990-1991

1990-1991  
1990-1991

**FUNERAL DIRECTOR: IMPORTANT**

K-500  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12190		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		71 12190	
1. NAME OF DECEASED (Type or Print)		KENNEY NORMAN D.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH		Dec. 24, 1971   8:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MARYLAND - CITY OF BALTIMORE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
UNION MEMORIAL HOSPITAL				BALTIMORE		E. STREET AND NUMBER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years lost birthday)	
M		W		05-10-04		67		11. Under 1 Yr. Months: Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME		JOHN H. KENNEY		PHILADELPHIA		U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME		JENNIE BURLING			
18. 205.11		CAUSE OF DEATH		17. INFORMANT		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CHRONIC MYELOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF:		18. II ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:			
		(C) ASCVD & Peripheral Vascular Disease							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
O						(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-02-71 to 12-24-71 that (I) (we) last saw the deceased alive on 12-24-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. DATE SIGNED			
JAIRO RAMIREZ		M.D. DEGREE		UNION MEMORIAL HOSPITAL		12-24-71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIUM		24D. LOCATION (City, town, or county)			
12/28/71		12/28/71		ANATOMY BOARD OF MARYLAND		(State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF RELEASER		25C. MEDICAL DIRECTOR		25D. ADDRESS			
JAN 5 1972		RUBEN RAMIREZ		UNIVERSITY MEDICAL SCHOOL		MORTUARY SERVICE - BCHD			

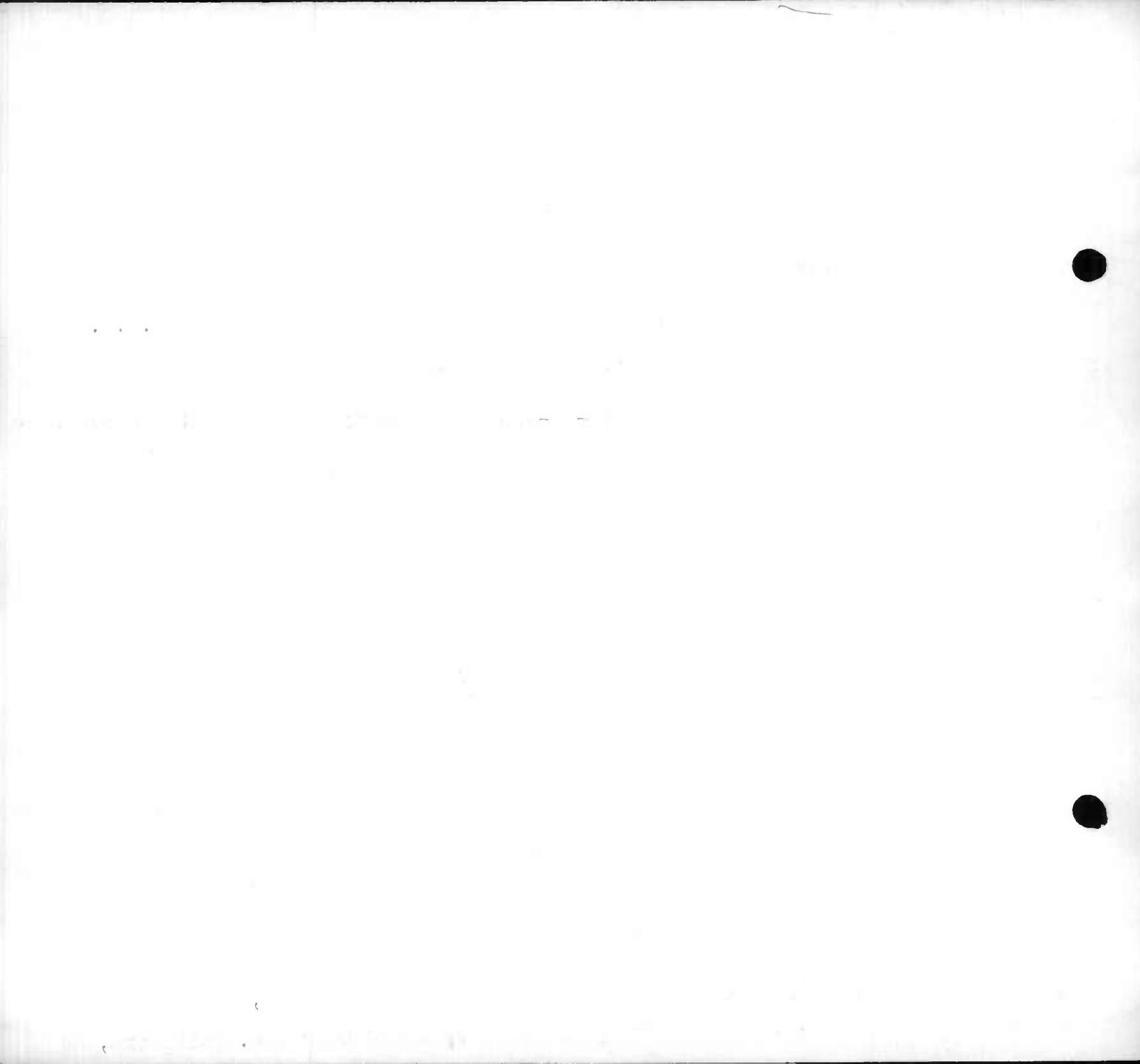
the following day. The author was present at the meeting and was able to observe the discussion.

#### VI. CONCLUDING REMARKS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		71 12191		BALTIMORE CITY HEALTH DEPARTMENT		71 12191	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.			
1. NAME OF DECEASED (Type or Print)		BELL GEORGE N		2. DATE AND HOUR OF DEATH		8:05 PM 12/31/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		5. SEX		6. RACE	
FULL NAME OF HOSPITAL OR INSTITUTION <small>(If not in hospital or institution, give street address or location)</small>		A. STATE Maryland		A. STATE Maryland		B. COUNTY BALTO 5300	
Lutheran Hospital of Maryland		C. CITY OR TOWN Baltimore		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouse Man		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 76		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Anne		12. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-05-3502		17. INFORMANT Mr George W Bell 5031 Truesdale Av		18. CAUSE OF DEATH Pulmonary Decompensation (Ventilatory failure)		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Stating the UNDERLYING CONDITION lost.	
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ch. pulmonary (obstructive) emphysema		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. I CERTIFY THAT (I) (THIS HOSPITAL) ATTENDED THE DECEASED FROM 12-30 - 1971 TO 12-31 - 1971 THAT (I) (WE) LAST SAW THE DECEASED ALIVE ON 12-31 - 1971 AND THAT IN (MY) (OUR) OPINION DEATH OCCURRED ON THE DATE AND HOUR AND FROM THE CAUSES STATED ABOVE. (I) (WE) (DID) (DID NOT) VIEW THE BODY AFTER DEATH.		23. DATE OF OPERATION 1971		19. DATE FOR WHICH OPERATION WAS PERFORMED 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? In Baltimore City, give exact location		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 12-31-71	
23A. SIGNATURE Abdul Majid Memon MD		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23D. ADDRESS 730 Ashburton Street Baltimore Md 21216		23C. PHYSICIAN'S NAME (Type) Abdul Majid Memon MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIAL Loudon Park		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. Jan 4 1972		25B. NAME OF REGISTRAR Leonard J. Buck Inc.		25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Md	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12192		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12192	
1. NAME OF DECEASED (Type or Print)		ELMYRA P. HENDRIX		2. DATE AND HOUR OF DEATH Dec. 30, 1971		10 <sup>15</sup> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  90 LONG GREEN NURSING HOME				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION				B. COUNTY 2747			
5. SEX female RACE caucasian				C. CITY OR TOWN Ba ltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER 2900 Westfield Ave.			
7. DATE OF BIRTH 12-6-1890				8. AGE (In years lost birthday) 81		If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Patterson				14. MOTHER'S MAIDEN NAME Ella Vaughn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-01-1680		17. INFORMANT Alberta Coleman, 2900 Westfield Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  It this does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Pneumonia</i>			
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1971</u> to <u>Dec 30 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Dr. William G. Helfrich</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-31-71			
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich		23D. ADDRESS 5006 Roland Ave, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-72		24C. NAME OF CEMETERY OR CREMATORIUM Bethel Presbyterian Cem..		24D. LOCATION (City, town, or county) Madonna, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR R. E. [Signature] A.D. 0 0 0		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc. - Balti., Md. - 11		ADDRESS	

BL 9 J 1989

2000

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-463 71 12193

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

71 12193

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marjorie T. Flayhart

2. DATE AND HOUR OF DEATH

12/28/71

1245P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md  
B. COUNTY 907

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES  NO

E. STREET AND NUMBER

1740 Gorsuch Ave

5. SEX

6. RACE

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

May 20, 1906

9. AGE (In years  
less birthday)

65

If Under 1 Yr.  
Months: Doy. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Schoolteacher, retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles R. Flayhart

14. MOTHER'S MAIDEN NAME

Mary Magann

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214-40-5417

17. INFORMANT

Mr. Jerome C. Flayhart, 902 Beach Hiway,

Ocean City, Maryland

18. I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION first.

CAUSE OF DEATH

*Arteriosclerotic Heart Disease - enlarged heart  
myocardial failure*

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:  
*Hypertension CVD - left ventricular hypertrophy*

(B) DUE TO, OR AS A CONSEQUENCE OF:  
*Genetic arteriosclerosis*

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

I

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

II

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work  Not While At Work

22. I certify that (1) ~~the hospital~~ attended the deceased from  
that (1) ~~we~~ last saw the deceased alive on ~~12/18/71~~

1965 to 12/27 1971

and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) ~~we~~ (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

Dr. Donald W. Mintzer

DEGREE

Attending Phys.  Med. Director  Staff Phys.

23B. DATE SIGNED

12/30/71

23D. ADDRESS

3009 Evergreen Ave.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Dec. 31, '71 New Cathedral Cemetery

24C. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

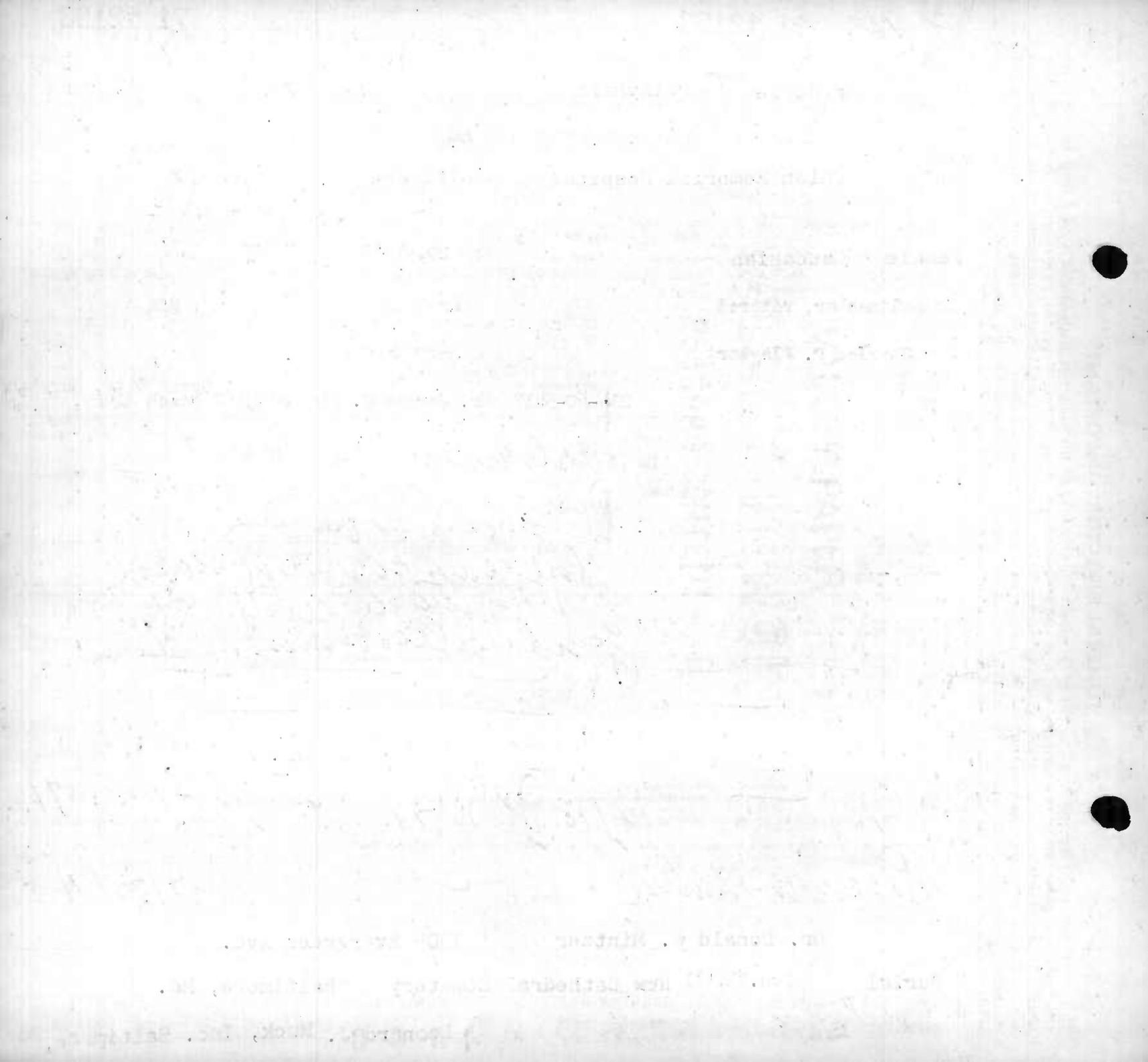
25B. NAME OF REGISTRAR

Ronald J. Ruck, Jr.

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc. Baltimore, Md.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. L-320 71 12194		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 12194
1. NAME OF DECEASED (Type or Print) <b>LUDWIG, FRANK J. Jr.</b>		2. DATE AND HOUR OF DEATH <b>12-30-1971 10:10 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED - 1/4/72 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTO 5300</b>
FULL NAME OF INSTITUTION <b>NOGATAN</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>RT #1 BOX 251, WHITE HALL MARYLAND</b>		E. STREET AND NUMBER <b>RT #1 BOX 251, WHITE HALL MARYLAND</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-31-09</b>	9. AGE (in years lost birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>603 Co. Helper.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Navy 1943-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>FRANK J. LUDWIG SR.</b>		14. MOTHER'S MAIDEN NAME <b>EMILY KOESEL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-01-0433</b>		17. INFORMANT <b>Mrs. Grace C. Ludwig</b>
18. <b>410-9</b> I 1945		CAUSE OF DEATH <b>CARDIAC ARREST</b>		ADDRESS <b>(Same)</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypocardial Infarction.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis cardiovascular dis.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from shot (I) (we) lost saw the deceased alive on		<b>12-28 1971 to 12-30 1971</b>		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
23A. SIGNATURE <b>Gattilana</b>		Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Carlos A. Gattilana MD</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL MD.</b>		23B. DATE SIGNED <b>12-30-71</b>
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE <b>12/31/71</b>		24C. NAME OF CEMETERY or CREMATORIAL <b>Parkwood Cemetery</b>
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Buck, Inc. Balto. Md. 21214</b>
25C. FUNERAL DIRECTOR <b>Leonard J. Buck, Inc. Balto. Md. 21214</b>		ADDRESS		

1/13/72 - Letter from Union Memorial Hospital dated 1/7/1972. Signed by M's.

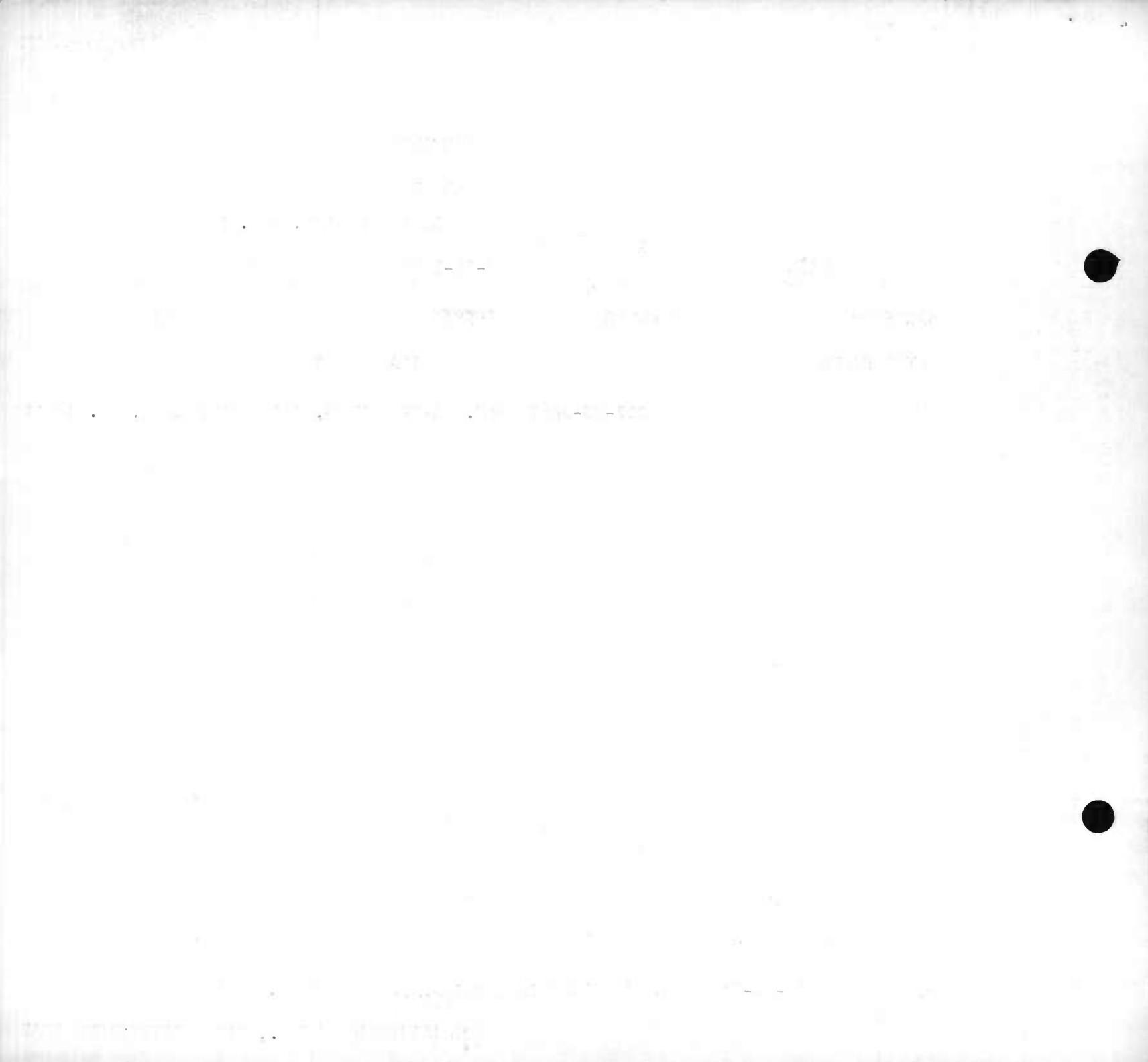
Theresa M. Winter, RRA, Director, Medical Records.

LJRC

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

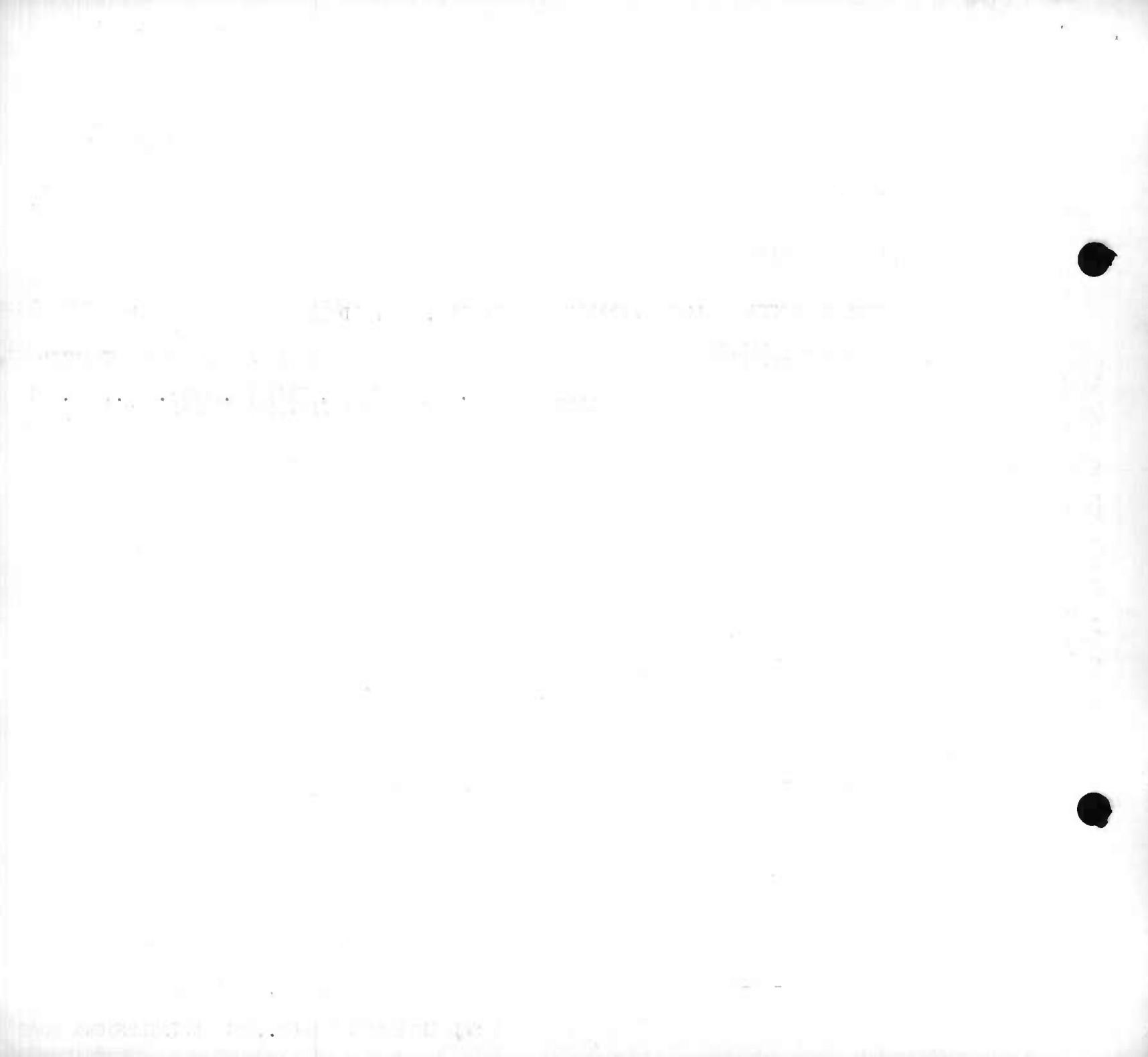
S-220 BIRTH NO.		71 12195		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12195	
1. NAME OF DECEASED (Type or Print)		SYKES		2. DATE AND HOUR OF DEATH 12/29/71 10:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720  C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 4012 FORDS LANE, APT. 1A			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CLOTHES		9. AGE (In years last birthday) 82		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MEYER SACHS		14. MOTHER'S MAIDEN NAME IDA ?		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-9697		17. INFORMANT MRS. HATTIE SYKES, 4012 FORDS LANE, APT. 1A #15		ADDRESS	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION (B).  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1455 19 to 12/29 1971 that (I) (we) last saw the deceased alive on 12/20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  A. A. SILVER		23B. DATE SIGNED  12/29/71					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS  6210 PARK HTS AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORIUM BNAI ISRAEL (MISHKON ISRAEL SECTION)		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
25A. DATE TIED BY HEALTH DEPT. 12/29/71		25B. NAME OF REGISTRAR 971000		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	
VS 150-REV. 1/1/68							



## FUNERAL DIRECTOR: IMPORTANT

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K-500 BIRTH NO.		71 12196		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 522-400 71 12196	
1. NAME OF DECEASED (Type or Print)		CYRIL W. KEENE		2. DATE AND HOUR OF DEATH DEC. 29, 1971		6:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE CITY B. COUNTY STATE BALTIMORE, MARYLAND 2730		5. STREET AND NUMBER CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 7111 PARK HEIGHTS AVE. H15	
FULL NAME OF HOSPITAL OR INSTITUTION  SINAI HOSPITAL		6. RACE MALE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX BROKER		10B. KIND OF BUSINESS OR INDUSTRY LOAN XXXXXX		11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND XXX		9. AGE (in years lost birthday) 83	
13. FATHER'S NAME WILLIAM CHARLES KEENE		14. MOTHER'S MAIDEN NAME XXXXXX ROSINA MIRIAM TRAVISH		12. CITIZEN OF WHAT COUNTRY? U.S.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. XXXX		17. INFORMANT MRS. ELLEN KEENE, 7111 PK. HEIGHTS AVE., APT. 811 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH  CARDIO-PULMONARY ARREST  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:  (A) CARCINOMA OF HEAD OF PANCREAS  C METASTASIS MI & POSS. PNEUMONIA		FEW HOURS			
MEDICAL CERTIFICATION  19A. DATE OF OPERATION 11/23/71 12/12/71 Weight loss & vomiting		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Weight loss & vomiting		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOV 15 19 71 to DEC. 29 19 71 that (I) (we) last saw the deceased alive on DEC. 29 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  C. Keene, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-31-71			
23C. PHYSICIAN'S NAME (Type) CATHERINE T. Dizon, M.D.		23D. ADDRESS SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-71		24C. NAME OF CEMETERY or CREMATORIUM OHEB SHALOM		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 7 1 0 0 0		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



S-632

71 12197

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12197

REG. NO.

BIRTH NO.

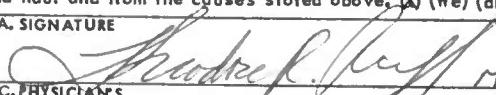
1. NAME OF DECEASED (Type or Print) JULIUS SCHWARTZ			2. DATE OF DEATH Known <input type="checkbox"/> Month _____ Day _____ Year _____ Hour _____ Estimated <input type="checkbox"/>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET OR INSTITUTION ADDRESS OR LOCATION <b>CERTIFICATE AMENDED</b> 3101 Swan Drive			3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____ December 29, 1971 11:00 A.M.
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <input checked="" type="checkbox"/> MARYLAND B. COUNTY <input checked="" type="checkbox"/> BALTIMORE XXXXX BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH JAN. 18, 1907	10. AGE (In years at time of death) 64	11. Months: Days: Hours: Min.	E. STREET AND NUMBER XXXX 6821 WESTRIDGE ROAD
11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME WILLIAM SCHWARTZ
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>TRAFFIC CHECKER</del>		14B. KIND OF BUSINESS OR INDUSTRY <del>TRAFFIC &amp; TRANSIT DEPT.</del>	15. MOTHER'S MAIDEN NAME IDA KEISLER
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	17. SOCIAL SECURITY NO. 185-07-1186	18. INFORMANT MRS. MINNIE SCHWARTZ, 6821 WESTRIDGE RD. #2120	ADDRESS
19. CAUSE OF DEATH E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Unk.	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unk.
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) Missing 12/20/71 ?	22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR? Found shot in park	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Ronald N. Kornblum</i> , M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12/29/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-30-71	24C. NAME OF CEMETERY or CREMATORIES BOBROISKER BENEFICIAL CIRCLE	24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972	25B. NAME OF REGISTRAR R. LEVINSON & BROS.	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	ADDRESS

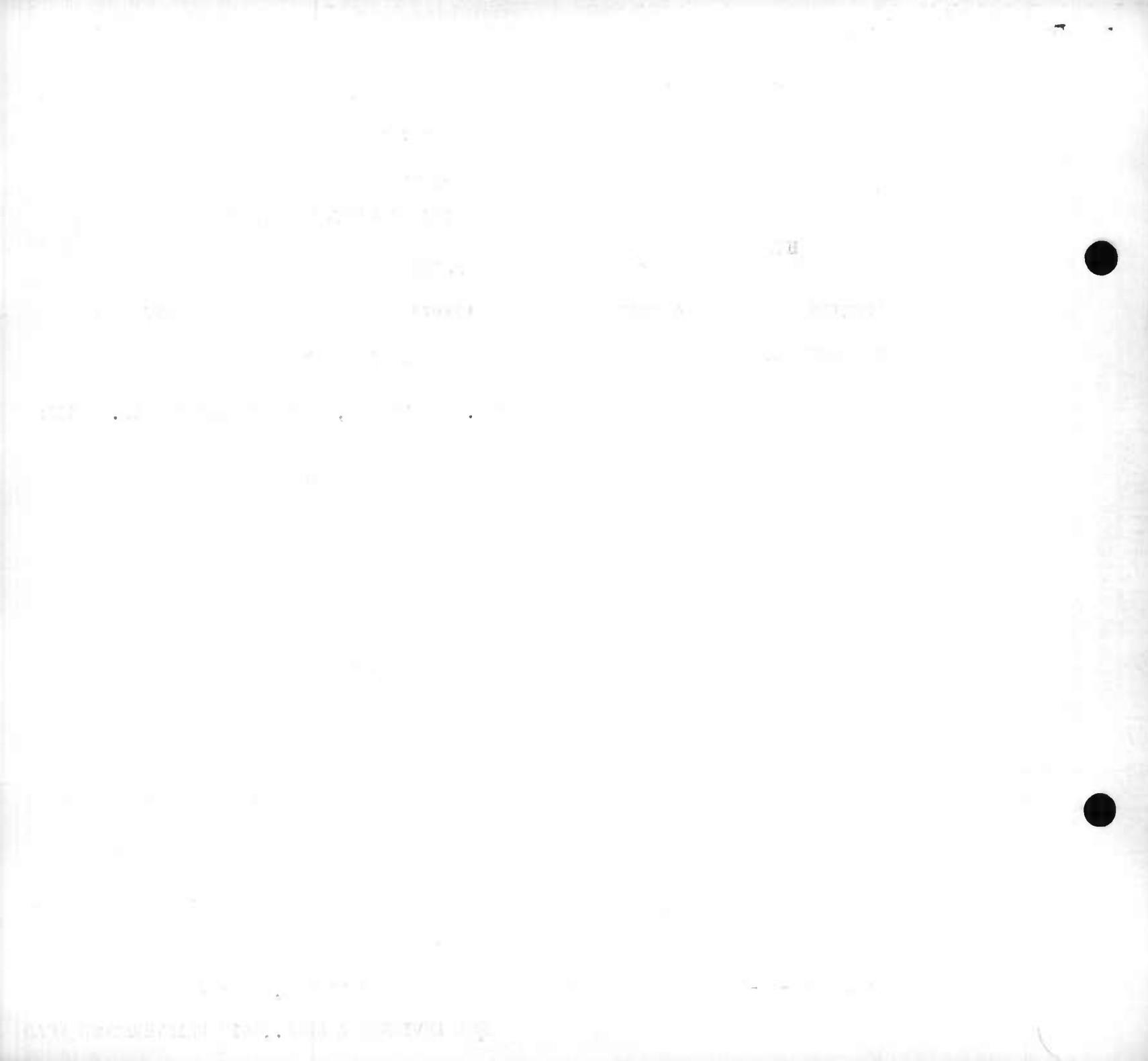
~~1110472XX~~

1-10-72 - Letter from - Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

**FUNERAL DIRECTOR: IMPORTANT**

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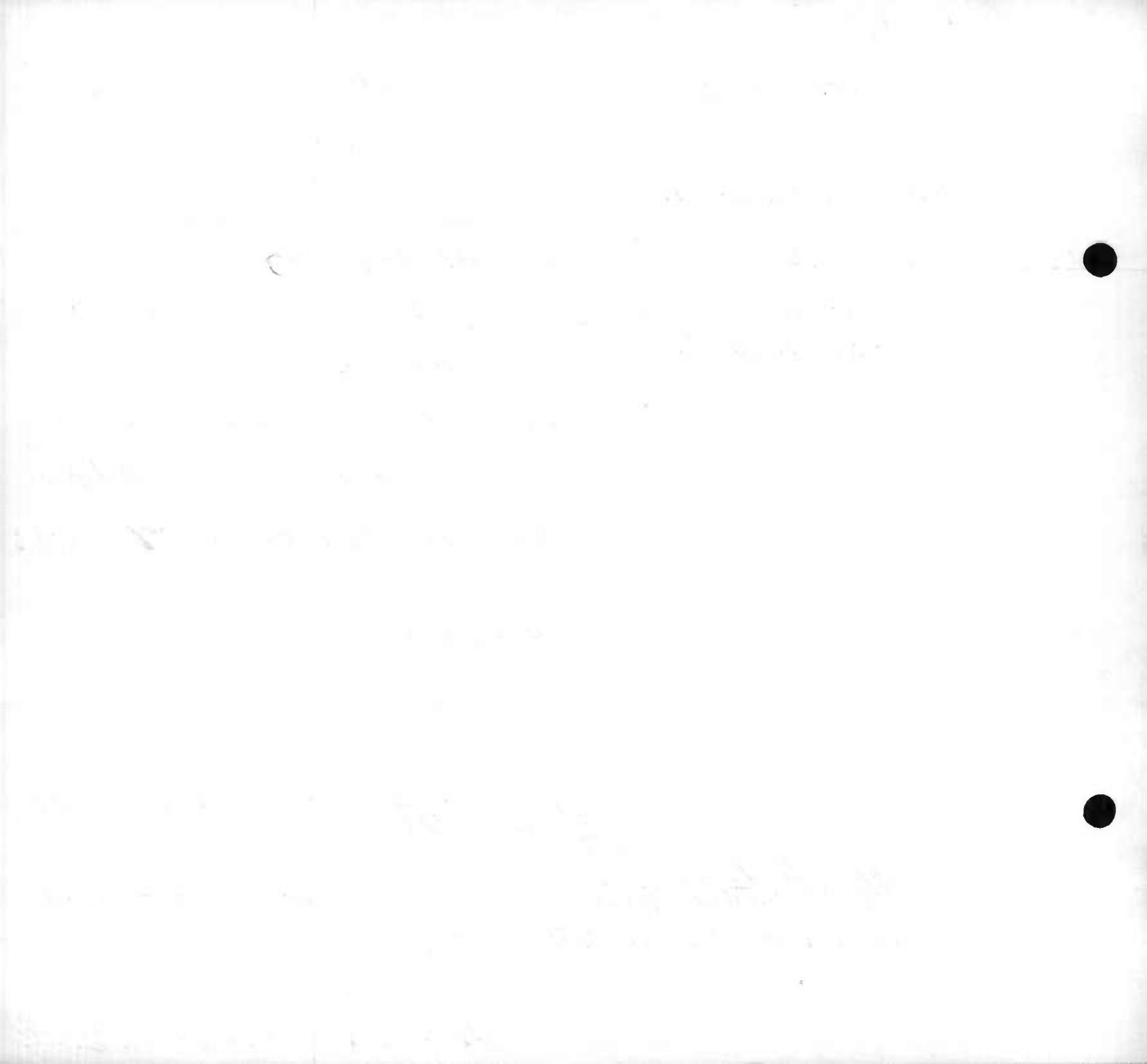
S-542		71 12198		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12198	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		SARAH SAMUELSON				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						December 27, 1971		11:20 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission)			
91 LEVINDALE				A. STATE MARYLAND		B. COUNTY		2740	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3108 PARKINGTON AVENUE					
5. SEX Female		6. RACE WHITE Human		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH XK80X		9. AGE (in years last birthday) 99	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ISAAC HOFFMAN				14. MOTHER'S MAIDEN NAME LENA ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ANN FISHER, 3108 PARKINGTON AVE. #21215		ADDRESS			
18. 486X I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE Recurrent Pneumonia DUE TO, OR AS A CONSEQUENCE OF:		Weeks			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(C) _____					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> ) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		Yes			
						(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 6 1965 to December 27 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 27 1971 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) <input type="checkbox"/> (will) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				December 28, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
Theodore R. Reiff, M.D.		Levindale							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-29-71		24C. NAME OF CEMETERY OR CREMATORIUM SHAAREI TFILOH		24D. LOCATION BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR S. J. Levinson, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

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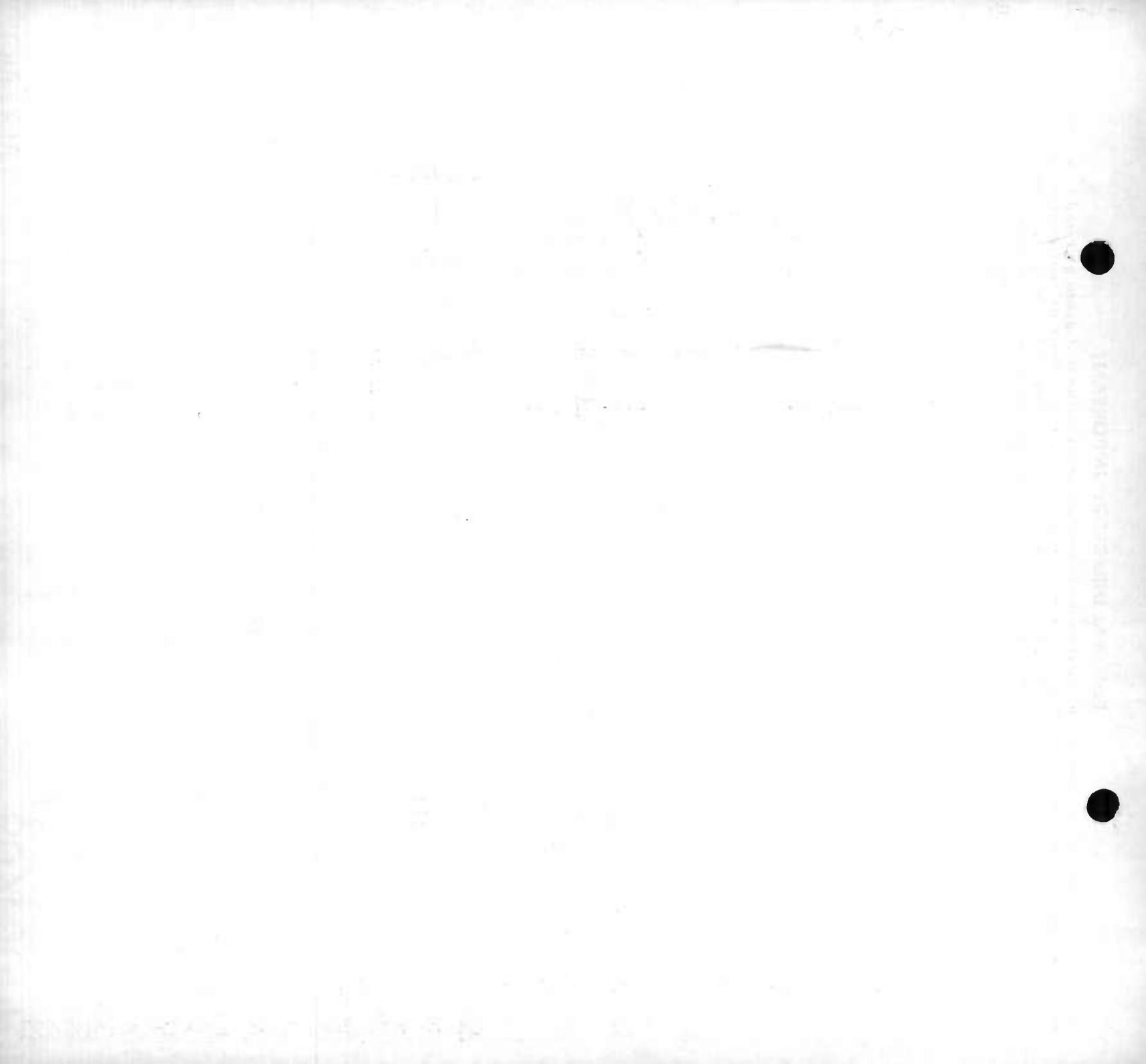
M-460		71 12199	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12199		
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		<i>John H. Miller</i>		2. DATE AND HOUR OF DEATH <i>12/30/71</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore 2633</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. Univ of Maryland				E. STREET AND NUMBER <i>3113 Kenyon Ave</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/25/99</i> 9. AGE (in years last birthday) <i>72</i>		10. KIND OF BUSINESS OR INDUSTRY <i>WORKING CAN MFG. CO.</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Miller</i>				14. MOTHER'S MAIDEN NAME <i>Minnie C. Miller</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>	
				16. SOCIAL SECURITY NO. <i>215-05-5184</i>		17. INFORMANT <i>Lewis H. Miller, 312 Beechwood B. 2722</i>	
				18. CAUSE OF DEATH <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
				(A) IMMEDIATE CAUSE <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <i>stem-cell leukaemia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i>		(C) <i>ASCVD</i>	
II MEDICAL CERTIFICATION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on <i>12/30/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alan G. Stahl, M.D.</i>		Degree Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/30/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Alan G. Stahl, M.D.</i>		Degree 23D. ADDRESS <i>Univ. Hosp.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Bur.</i>		24B. DATE <i>3/1/72</i>		24C. NAME & CEMETERY OR CREMATORIAL <i>CORSAINE MAUSOLEUM</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1972</i>		25B. NAME OF REGISTRAR <i>John E. Weber, Jr.</i>		25C. FUNERAL DIRECTOR <i>CERKES FERNAL HOME, BALTO. MD. 21206</i>		ADDRESS	
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant or his successor in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

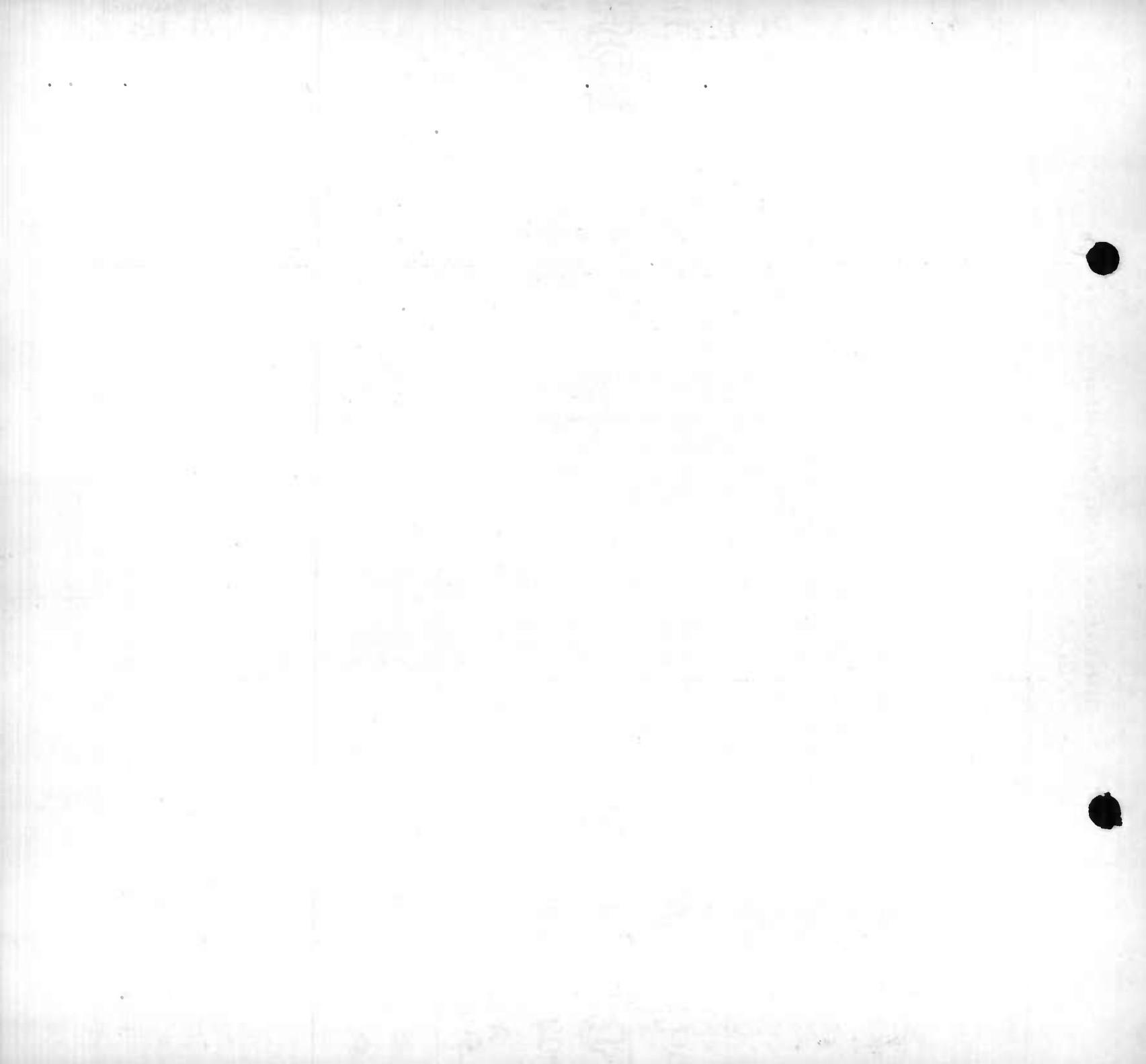
B-400		71 12200	BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X	REG. NO. 71 12200	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		Thomas J. Boyle		2. DATE AND HOUR OF DEATH		December 29 '71 18:40 p		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		B. COUNTY Baltimore		C. CITY OR TOWN Dundalk			
5. SEX Male		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/01		9. AGE (in years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas W.M.D. Boyle		14. MOTHER'S MAIDEN NAME MARY ADAMS							
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-9080		17. INFORMANT BCH RECORDS:		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  II		20. CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF:  Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. DATE OF OPERATION 1/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____ to _____ that <input type="checkbox"/> (we) last saw the deceased alive on December 29 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE Chu-shin Chiu MD		23B. DATE SIGNED 12-29-71							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS CHU-SHIN CHIU, MD. Baltimore City Hospitals							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3 JAN 72		24C. NAME of CEMETERY or CREMATOR Y JACKED HEART Cem.		24D. LOCATION BALTO. CO., MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
VS 150-REV. 1/1/68						HERRICK FEDERAL HOME, DUNDALK, MD. 21222			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-260		71 12201	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12201
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		William E. Tucker Sr.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH Dec 30, 1971 12:30 P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2534		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto		
327 Washburn Ave		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
OO		E. STREET AND NUMBER 327 Washburn Ave 21225		
5. SEX M	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1898	9. AGE (in years lost birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Bar Tender	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Isaac Tucker		14. MOTHER'S MAIDEN NAME Cora Collins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212 10 5695	17. INFORMANT Katherine Tucker 327 Washburn Ave 21225	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ospheno, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:  (B) Actual Fibrillation and DUE TO, OR AS A CONSEQUENCE OF:  (C) Cerebral Vascular Disease		
II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1964 1964 to Dec 30 1971 that (I) (we) last saw the deceased alive on December 24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Mario J. Reda MD		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/30/71	
23C. PHYSICIAN'S NAME (Type) MARIO J. REDA MD.		23D. ADDRESS 4016 RITCHIE Hwy BALTO, MD 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72	24C. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	24D. LOCATION (City, town, or county) Ritchie Hwy Balto Md. 21225
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Murphy Jr.	25C. FUNERAL DIRECTOR McGilly Funeral Home	ADDRESS 237 Patapsco Ave 21225



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

T-400 BIRTH NO.		71 12202	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12202		
1. NAME OF DECEASED (Type or Print)		ADOLPH ( ADOLPHUS ) H. THIELE		2. DATE AND HOUR OF DEATH December 30, 1971		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland      B. COUNTY Baltimore 5300		5. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION  40 St. Agnes Hospital		C. CITY OR TOWN Baltimore		E. STREET AND NUMBER 167 Stafford Street 21227			
6. SEX Male      7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 6-23-1893      10. AGE (in years lost birthday) 78		If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspector		10B. KIND OF BUSINESS OR INDUSTRY State of Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry W. Thiele		14. MOTHER'S MAIDEN NAME Kathe ( Unknown )		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 217-20-1823	
17. INFORMANT Mrs. Margaret M. Thiele, 167 Stafford St.		18. CAUSE OF DEATH  I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  II		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Acute myocardial infarction sudden	
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21C. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21F. TIME (Month) (Day) (Year) (Hour) (Approx.)		21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE  Dr. Frederick		23B. DATE SIGNED  12/31/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-1972		24C. NAME OF CEMETERY OR CREMATORIAL Lake View Memorial Park		24D. LOCATION (City, town, or county) Carroll County, Maryland	
25A. DATE REC'D. BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	
VS 150-REV. 1/1/68							

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320 71 12203

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12203

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WATTS, SALOME A.

2. DATE AND HOUR OF DEATH

DECEMBER 28, 1971

9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. II institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES NO 

E. STREET AND NUMBER

4404 CEDAR GARDEN ROAD

21229

5. SEX

6. RACE

FEMALE CAUCASIAN

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

08/12/10

9. AGE (in years  
last birthday)

64

If Under 1 Yr.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HERBERT A. WHEELER

15. Was Deceased Ever In U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

16. 753-0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

## CAUSE OF DEATH

Ventricular fibrillation

Intracardiac

Pulm. edema

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 days

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

My periphery of heart 2°

to by perthesion

(B) DUE TO, OR AS A CONSEQUENCE OF:

Congenital hypoplastic kidneys

Old brain infarction right

Occlusion right renal artery

(C)

## MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

2

20A. AUTOPSY? (Yes or No)

YFS

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g. in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?While At Work Not While At Work At Work 

(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work Not While At Work At Work 

21F. HOW DID INJURY OCCUR?

22. I certify that (I)  (this hospital) attended the deceased fromthat (I)  (we) last saw the deceased alive onand that in (my)  (our) opinion death occurred on the dateand hour and from the causes stated above. (I)  (We)  (did)  (did not) view the body after death.

23A. SIGNATURE

JOSE APTER, M.D.

23B. DATE SIGNED

DEGREE

Attending Phys. Med. Director Staff Phys. 23C. PHYSICIAN'S  
NAME (Type)

ST AGNES HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial 1-3-1972

24B. DATE

Crestlawn Cemetery

24C. NAME OF CEMETERY OR CREMATORIUM

Howard County, Maryland

24D. LOCATION  
(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 1 1972

25B. NAME OF REGISTRAR

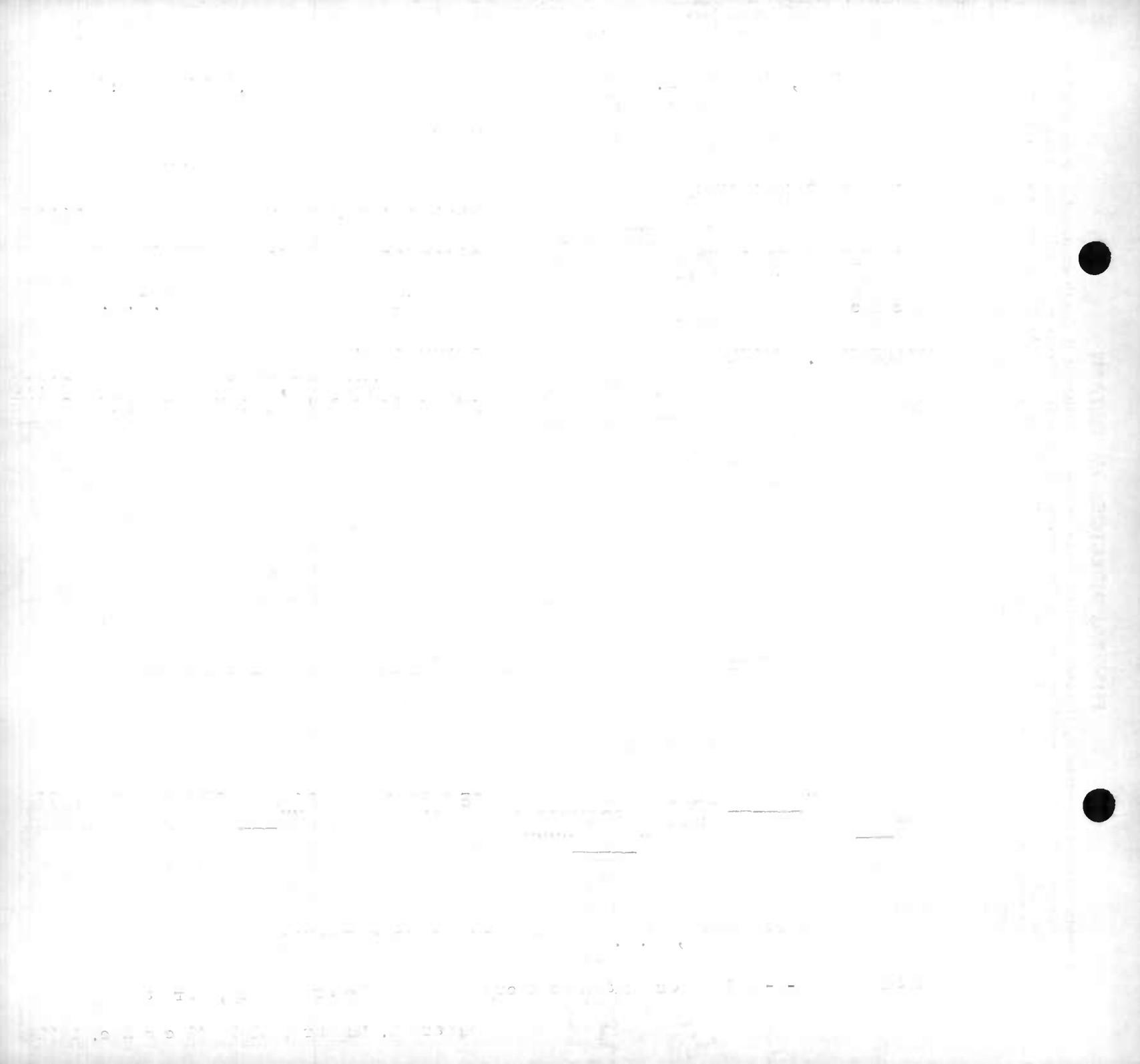
Ruth E. Hubbell, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave., 21229

ADDRESS

VS 150-REV. 1/1/68



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any kind; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

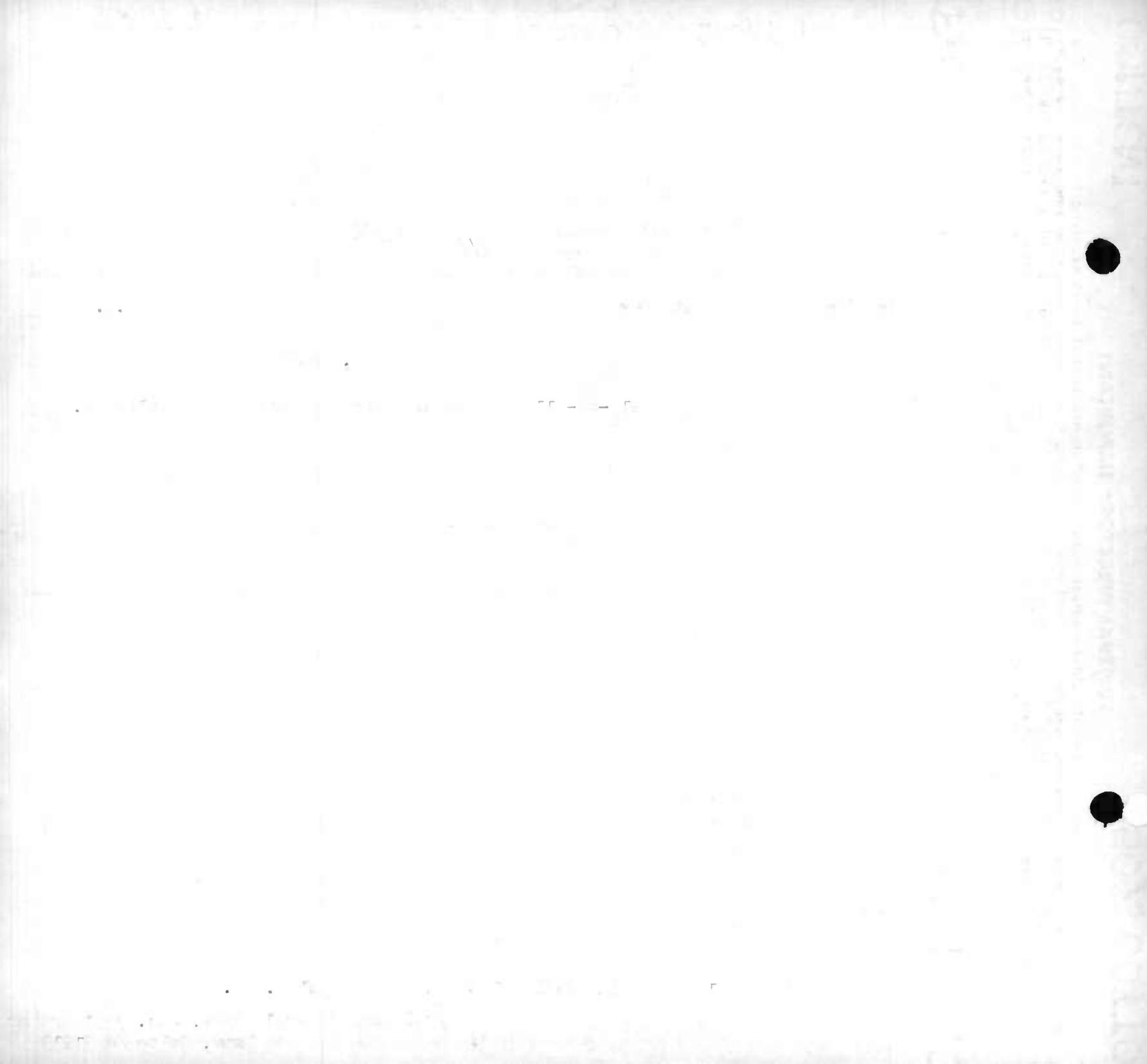
M-320 71 12204		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12204
1. NAME OF DECEASED (Type or Print) <b>MATTOX, FRANK</b>		2. DATE AND HOUR OF DEATH <b>12/29/71 6:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  THE JOHNS HOPKINS HOSPITAL <b>33</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  A. STATE & COUNTY <b>MARYLAND 903</b>		
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>601 E 34TH ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-16</b>	9. AGE (In years lost birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sears Robuck Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Wolcott, Ind.</b>
13. FATHER'S NAME <b>MATTOX, PERMAN</b>		14. MOTHER'S MAIDEN NAME <b>KEAN, EMMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>305-18-9772</b>		17. INFORMANT <b>Marjorie L Mattox 601 E. 34th St</b>
18. <b>396.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  <i>Attempted Suicide + Heart Valve Replacement</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS</b>
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Rheumatic Valve Replacement</i>		
		(B) DUE TO, OR AS A CONSEQUENCE OF:  <i>Rheumatic Valve Replacement</i>		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>1/2/79/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rheumatic Heart Disease</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on <b>12/29/71</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE  <i>James R. Reynolds MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/29/71</b>
23C. PHYSICIAN'S NAME (Type) <b>JAMES R. REYNOLDS</b>		23D. ADDRESS  <b>THE JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/72</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>MeadowLake Presbyterian</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Donovan Funeral Home</b>
				ADDRESS <b>3818 Roland Ave</b>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-560		71 12205	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	X REG. NO. 71 12205
BIRTH NO.		2. DATE AND HOUR OF DEATH Dec. 25 1971 6:30 PM			
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
KNORR MARIE A		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. CITY OF BALTIMORE B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/3/08		9. AGE IN YEARS 66-03-08 63		If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Frederick F. LINDHOURST			
14. MOTHER'S MAIDEN NAME KOTRA? Mary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 215-64-8715	
17. INFORMANT Norman Knorr (husband) 7248 Conley St.		18. CAUSE OF DEATH 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF:					
(B) Post-Necrotic cirrhosis DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. I certify that (I) (this hospital) attended the deceased from 11-05-71 to 12-25-71 that (I) (we) last saw the deceased alive on 12-25-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
MEDICAL CERTIFICATION		23A. DATE OF OPERATION O		23B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? IN Baltimore City, give exact location	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE <i>Rainer</i>					
23C. PHYSICIAN'S NAME (Type) JAIRO RAINER		23D. ADDRESS UNION MEMORIAL HOSPITAL		23E. DATE SIGNED 12-25-71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/29/71		24C. NAME OF CEMETERY OR CREMATORIAL Bohemian National Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehm Lane, Baltimore Md. 21213	
ADDRESS					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-352		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12206	
BIRTH NO. 71 12206					
1. NAME OF DECEASED (Type or Print) MARY J. ADAMS				2. DATE AND HOUR OF DEATH 12/31/71 2:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 602	
FULL NAME OF HOSPITAL OR INSTITUTION				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2538 E. FAYETTE ST.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/06/07	9. AGE (in years lost birthday) 67	If Under 1 Yr. Months Days Hours II Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) West Virginia	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JINK SEARS				14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown! If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 236242822	
				17. INFORMANT Mrs Henry Heile 1924 35th St.	
				ADDRESS Balto 37	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UREMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
				(B) DUE TO, OR AS A CONSEQUENCE OF: MIX ED MESODERMAL TUMOR 6 MONTHS	
				(C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
20A. DATE OF OPERATION 198. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. SPOONER				23B. DATE SIGNED 12/31 2:20 PM	
23C. PHYSICIAN'S NAME (Type) M. SPOONER		23D. ADDRESS 1034 Woodson Rd. Apt. BALT. MARYLAND			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 1/3/72		24C. NAME OF CEMETERY or CREMATORIAL Parkwood Cemetery		24D. LOCATION (City, town, or county) Balto. Ind.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Bailey, Jr., D.D.		25C. FUNERAL DIRECTOR Philip E. Koch, 1211 Chesapeake	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.Q.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-261		71 12207	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12207		
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 12/30/71 7:45 AM			
1. NAME OF DECEASED (Type or Print)		RUTH MARGARET DeGRAFFT		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
De GRAFFT - RUTH MARGARET		5. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		A. STATE MD		B. COUNTY HOWARD	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN ELICOTT CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
BON Secours Hospital 34		10109 CARILLON DR.		E. STREET AND NUMBER		11. BIRTHPLACE (State or foreign country) MD	
5. SEX Female		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/03/06	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOVAE		10B. KIND OF BUSINESS OR INDUSTRY N/A		9. AGE (in years last birthday) 65		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George Coppersmith Sr.		14. MOTHER'S MAIDEN NAME Margaret Slagle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/A			
16. SOCIAL SECURITY NO. 213-01-1220		17. INFORMANT Wm. E. DeGrafft		18. CAUSE OF DEATH metastatic ca of the breast, right			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. ANTECEDENT CAUSES		ADDRESS 10109 Carillon Dr. Ellicott City, Md.			
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE: metastatic ca of the breast, right DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
II		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. I CERTIFY THAT (I) (THIS HOSPITAL) ATTENDED THE DECEASED FROM 11/26/71 TO 12/30/71 THAT (I) (WE) LAST SAW THE DECEASED ALIVE ON 12/30/71 AND THAT IN (MY) (OUR) OPINION DEATH OCCURRED ON THE DATE AND HOUR AND FROM THE CAUSES STATED ABOVE. (I) (WE) (DID) (DID NOT) VIEW THE BODY AFTER DEATH.			
MEDICAL CERTIFICATION		23A. DATE OF OPERATION 19/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of breast		20A. AUTOPST? (Yes or No) N/A	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner) N/A		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Now While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A		23B. DATE SIGNED 12-30-71	
23A. SIGNATURE Gerardo M. Lopez		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) GERARDO M. LOPEZ			
23D. ADDRESS BON Secours Hospital		24A. BURIAL/CREMATION, REMOVAL (Specify) Burial Jan 3, 1972 Lorraine Park Cemt.		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 1 1972		25B. NAME OF REGISTRAR Robert F. Farley, Jr.		25C. FUNERAL DIRECTOR Sterling Funeral Estate		ADDRESS 736 Edmondson Ave.	
VS 150-REV. 1/1/68							

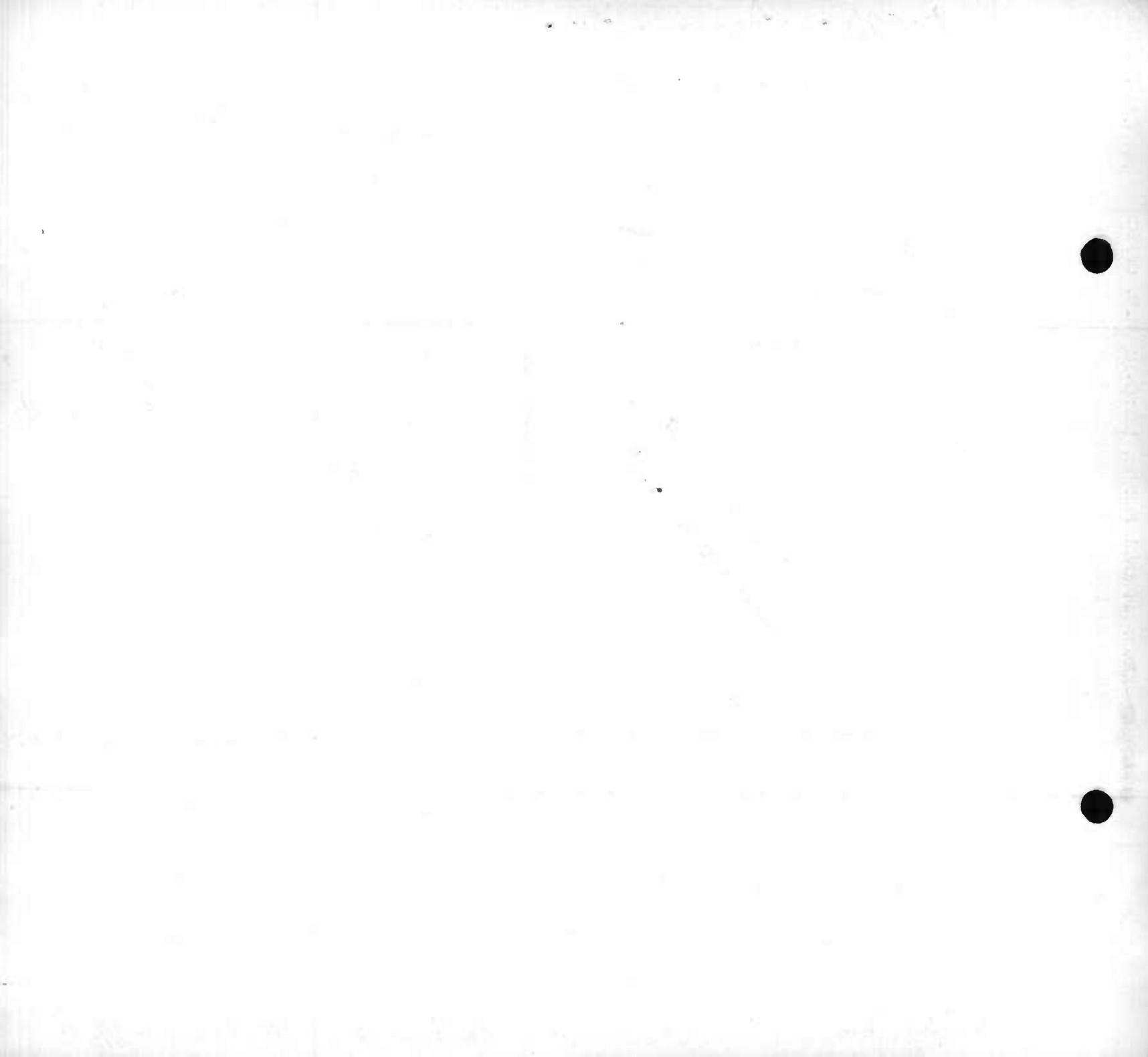


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

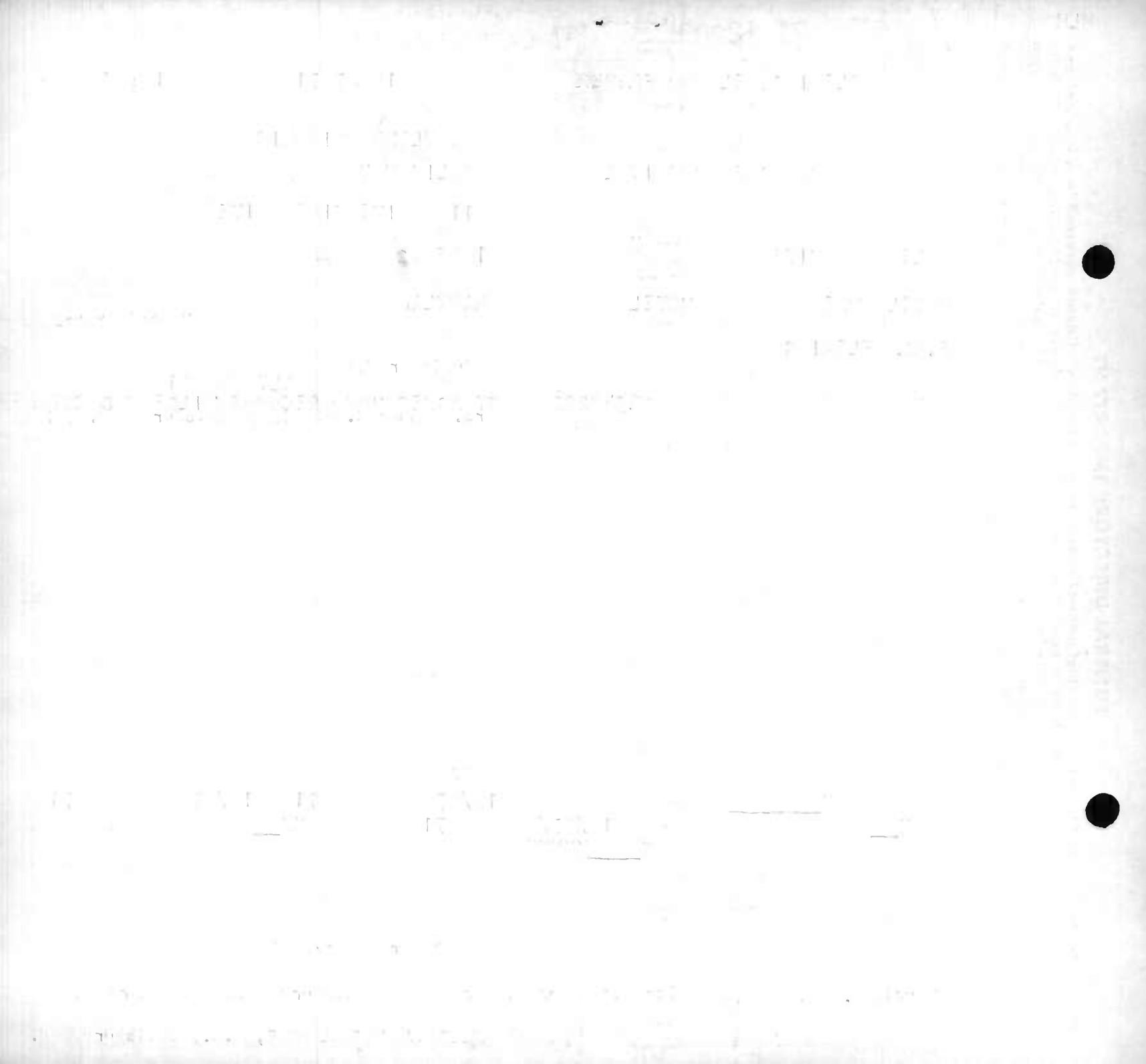
BIRTH NO.		Baltimore City Health Department		CERTIFICATE OF DEATH		REG. NO. 71 12208	
1. NAME OF DECEASED (Type or Print)		SADIE C. BANKS		2. DATE AND HOUR OF DEATH 12/25/71 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  300 W. HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived at time of residence before admission) A. STATE MARYLAND B. COUNTY RT 2, Box 183, Arundel, MD. 21002			
5. SEX FEMALE				6. RACE NEGRO			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/17/98			
9. AGE (in years last birthday) 73				10. KIND OF BUSINESS OR INDUSTRY			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME GRIFFIN ELT UNKNOWN			
14. MOTHER'S MAIDEN NAME 203811ME GRIFFIN. (HOLLAND)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 219 16 1210				17. INFORMANT Thomas Griffin, M.D.			
18. 199.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease or injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS WHICH ARE GIVING RISE TO THE ABOVE CAUSE (A), FOLLOWING THE UNDERLYING CONDITION (B).  RELEASER OF MEDICAL EXAMINER				CAUSE OF DEATH  (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:  (B) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF:  (C)			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Only medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME (In month) (In Day) (Year) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? JOHNS HOPKINS 601 N. BROADWAY			
22. I certify that (I) (this hospital) attended the deceased from 12/21/71 to 12/25/71 that (I) (we) last saw the deceased alive on 12/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did not) (did not) view the body after death.							
23A. SIGNATURE Robert C. Bast, M.D.				23B. DATE SIGNED 12/25/71			
23C. PHYSICIAN'S NAME (Type) Dr Robert Bast, M.D.				23D. ADDRESS 300 W. HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-29-71			
24C. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary				24D. LOCATION Arnold			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972				25B. NAME OF REGISTRAR Robert E. Nelson, M.D.			
25C. FUNERAL DIRECTOR William Rees, Anna, M.D.				25D. ADDRESS			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-455		71 12209	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	X REG. NO. 71 12209
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		FLEMING, ELWOOD FRANCIS		2. DATE AND HOUR OF DEATH 12 27 71 12:45 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  40 FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND WICOMICO 7200 B. COUNTY		M. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01 25 02 9. AGE (in years 69 for birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOTEL OWNER		10B. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Wm. J. FLEMING				12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 265402828		17. INFORMANT BALTO MD 21229 ST AGNES HOSP RECORDS WILKENS & CATON Mrs. Minnie C. Fleming, Salisbury, Md. (wife)	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 12		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12/27 19 71 to 12/27 19 71 that (X) (we) last saw the deceased alive on 12/27 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Lorraine G. Vargas Jr.		24. DEGREE M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-27-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24C. NAME OF CEMETERY or CREMATORIAL Wicomico Memorial Park		24D. LOCATION Salisbury, Wicomico, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert Englehart, Jr. DO		25C. FUNERAL DIRECTOR ADDRESS HOLLOWAY FUNERAL HOME, P.A., Salisbury, Md.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

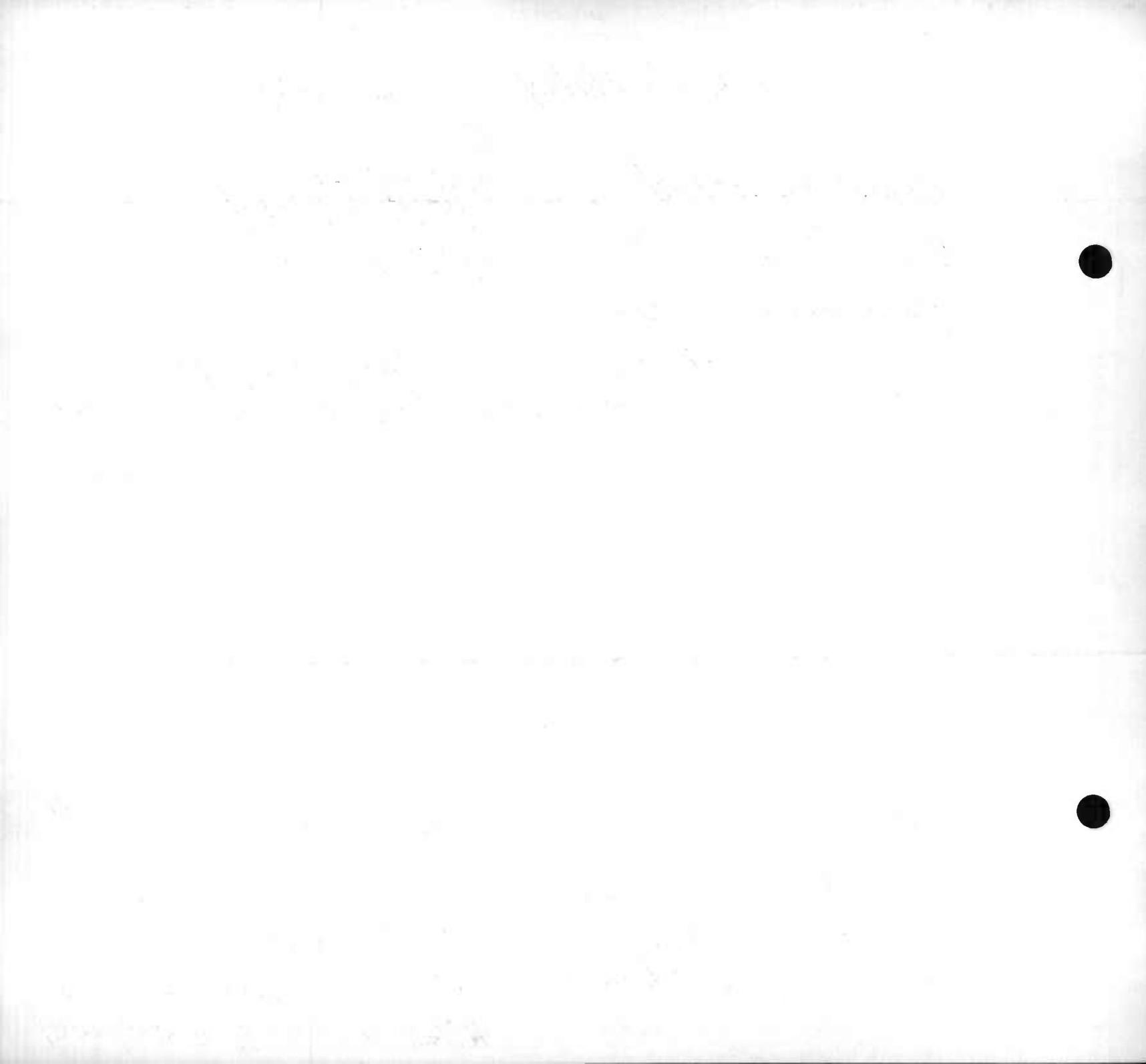
M-460		71 12210	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12210
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Dec. 29, 1971			
Emery E. Moeller					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  Ambassador Apts. # 201		A. STATE Md. B. COUNTY 1201			
(If not in hospital or institution, give street address or location)					
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER Ambassador Apts. 39th & Canterbury					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1906	9. AGE (in years last birthday) 75	If Under 1 Yr. Months: Days Hours If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comm. Merchant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 10 3894		17. INFORMANT Mrs. Clara L. Moeller Ambassador Apts	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE Myocardial Infarction 2 hours DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 4-30 1962 to 12-28 1972 that (I) (we) last saw the deceased alive on 11-24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-29-71	
23C. PHYSICIAN'S NAME (Type) FRANKLIN E. LESLIE MD		23D. ADDRESS 350 1st Paul St. Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 12/31/71	24C. NAME OF CEMETERY OR CREMATORIAL Lorraine Mausoleum	24D. LOCATION Woodlawn, Md.	(City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Vivian E. Harbo, R.D.C.P.	25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD	ADDRESS 6500 York Rd.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

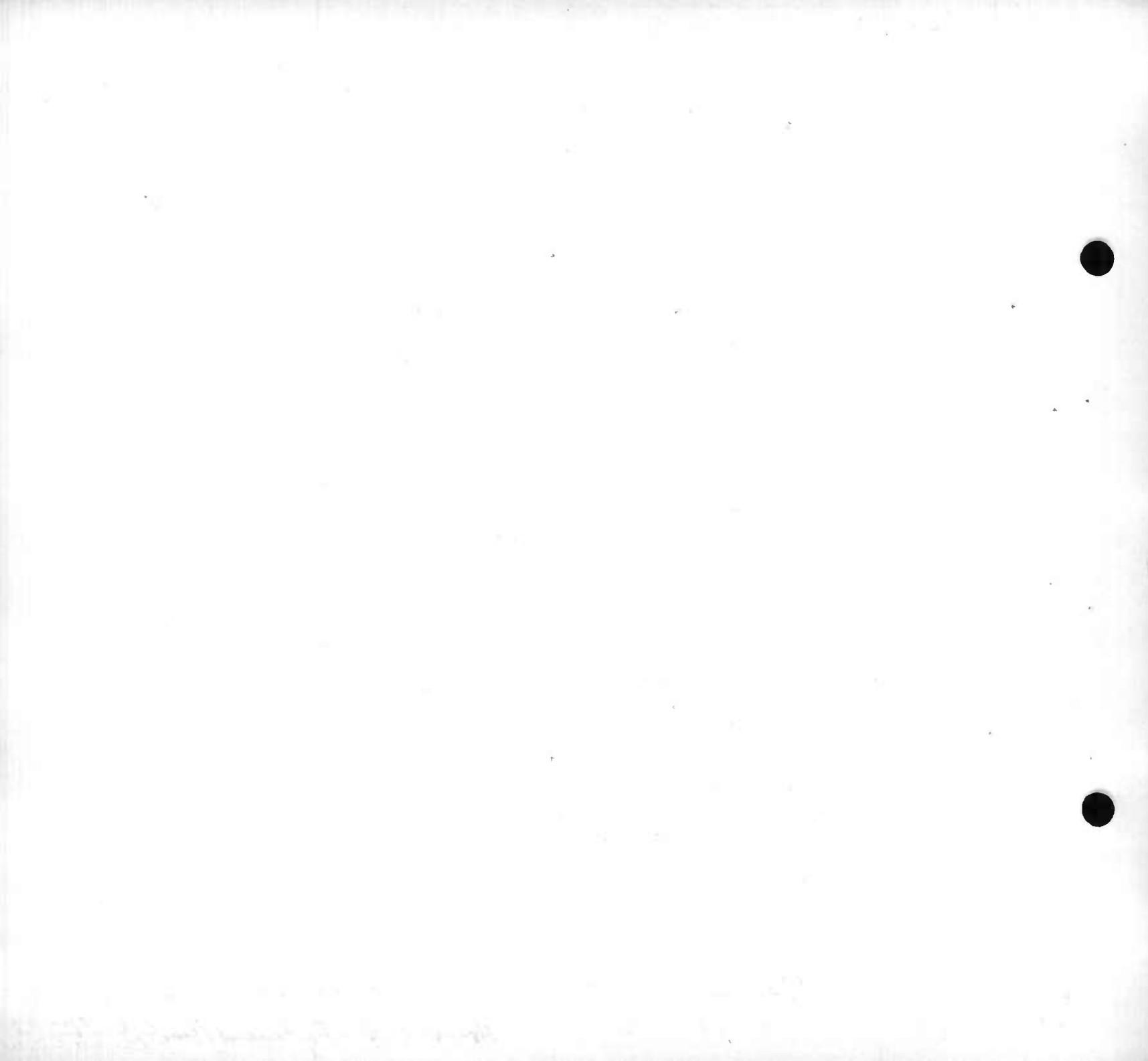
BIRTH NO.		71 12211	BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 12211
1. NAME OF DECEASED (Type or Print)		Frank J. Haley		2. DATE AND HOUR OF DEATH		12/25/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE	B. COUNTY	Conn V 06	
Union Memorial				C. CITY OR TOWN	Ridgefield	D. INSIDE CITY LIMITS?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX		6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	II Under 1 Yr. Months Days	II Under 24 Hrs. Hours Min.
Male		White		2/23/1898	73		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Retired Lawyer		Law					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Wm. Haley		Mary McKenna					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		130101736A		Mrs. Florence M. Haley		same	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arterio sclerotic vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Years	
		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						(If In Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (Month Day Year Hour APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 19 71 to Dec 19 71 tho (I) (we) last saw the deceased alive on Dec 16 19 71 and that In my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		Robert R. Kent M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/27/71		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	6701 N Charles St.		
Robert R. Kent				DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORI	24D. LOCATION	(City, town, or county) (State)		
Burial		12/29/71	Woodlawn Cemt	Woodlawn	Md		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS			
JAN 4 1972		Robert R. Kent, M.D.	Robert R. Kent	Woodlawn Home 6500 York Rd			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. G-619 72-01-17		71 12212		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. X 71 12212	
1. NAME OF DECEASED (Type or Print) <b>GRUBB, ISABELLE</b>				2. DATE AND HOUR OF DEATH <b>12/30/71</b>		<b>8:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b> <b>33</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE & COUNTY <b>Md Howard</b>			
				C. CITY OR TOWN <b>COLUMBIA Md</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>6300</b>	
				E. STREET AND NUMBER <b>5166 Evangelie Way</b>			
5. SEX <b>Fe</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-01-17</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months	II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N.C.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BROADBENT, Joseph</b>				14. MOTHER'S MAIDEN NAME <b>RHODES, SARA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. JOSEPH GRUBB 5166 EVANGELIE WAY</b>		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		Pulmonary Obstruction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) Metastatic Carcinoma in Lung DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Carcinoma of Breast			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>11/21/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Path Fix of Femur</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Dec 13 1971</b> to <b>Dec 30 1971</b> that <b>(1)</b> (we) last saw the deceased alive on <b>12/30 1971</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D M Haines</b>		MD DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>D M Haines</b>		23D. ADDRESS <b>601 N. Broadway</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/72</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>Crestlawn</b>		24D. LOCATION (City, town, or county) <b>R 40 Howard County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972</b>		25B. NAME OF REGISTRAR <b>Robert S. Bailey, R.D.</b>		25C. FUNERAL DIRECTOR <b>Howard County Funeral Home Cemetery Park</b>		ADDRESS <b>4112 Columbia Rd. Edgewater, Md.</b>	
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

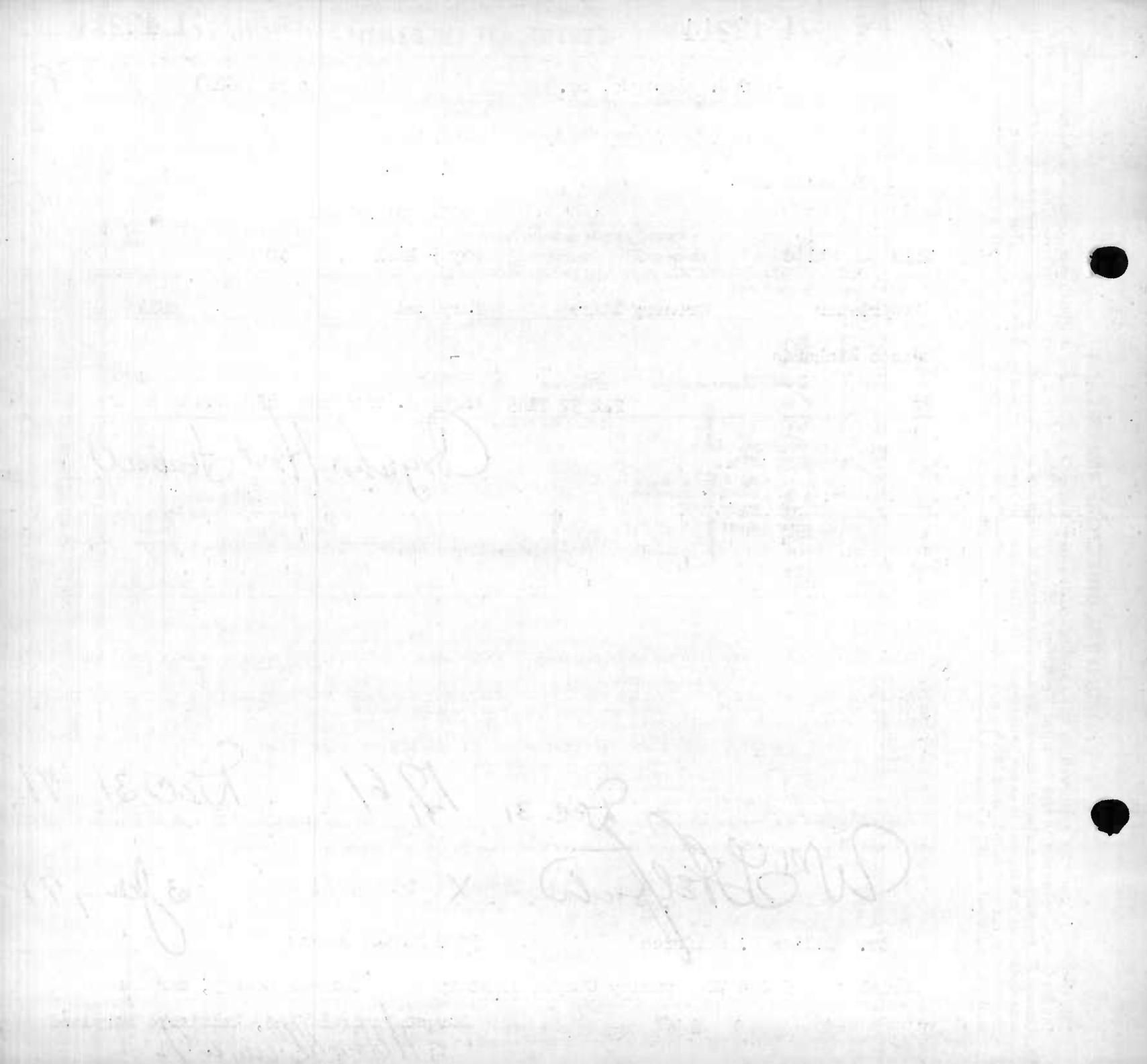
D-250		71 12213	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12213
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Dec. 29, 1971, 15 <sup>45</sup> A.M.			
DAWSON WILLIAM E					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. CITY OF BALTIMORE 1306			
(If not in hospital or institution, give street address or location)		B. COUNTY			
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3409 CHESTNUT AVE.					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEP <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-22-03	9. AGE (in years last birthday) 68	If Under 3 Yrs. Months Days Hours Years Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10B. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME Milton Monroe Dawson Unknown		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes		16. SOCIAL SECURITY NO. 049103529		17. INFORMANT Pearl M Fitzgerald Finksburg Md	
18. 410-9		CAUSE OF DEATH ACUTE MYOCARDIAL INFART			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-15-71 to 12-27-71 that (I) (we) last saw the deceased alive on 12-29-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DEGREE MD	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) JAIRO RAMIREZ		23D. ADDRESS UNION MEMORIAL HOSPITAL	23E. DATE SIGNED 12-29-71		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3 JAN 72	24C. NAME OF CEMETERY or CREMATORIUM Holly Hills Mem Garden	24D. LOCATION Baltimore Md	(City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Shultz MD	25C. FUNERAL DIRECTOR Bunge Funeral Home Baltimore Md	ADDRESS 1100 W. Pratt St.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

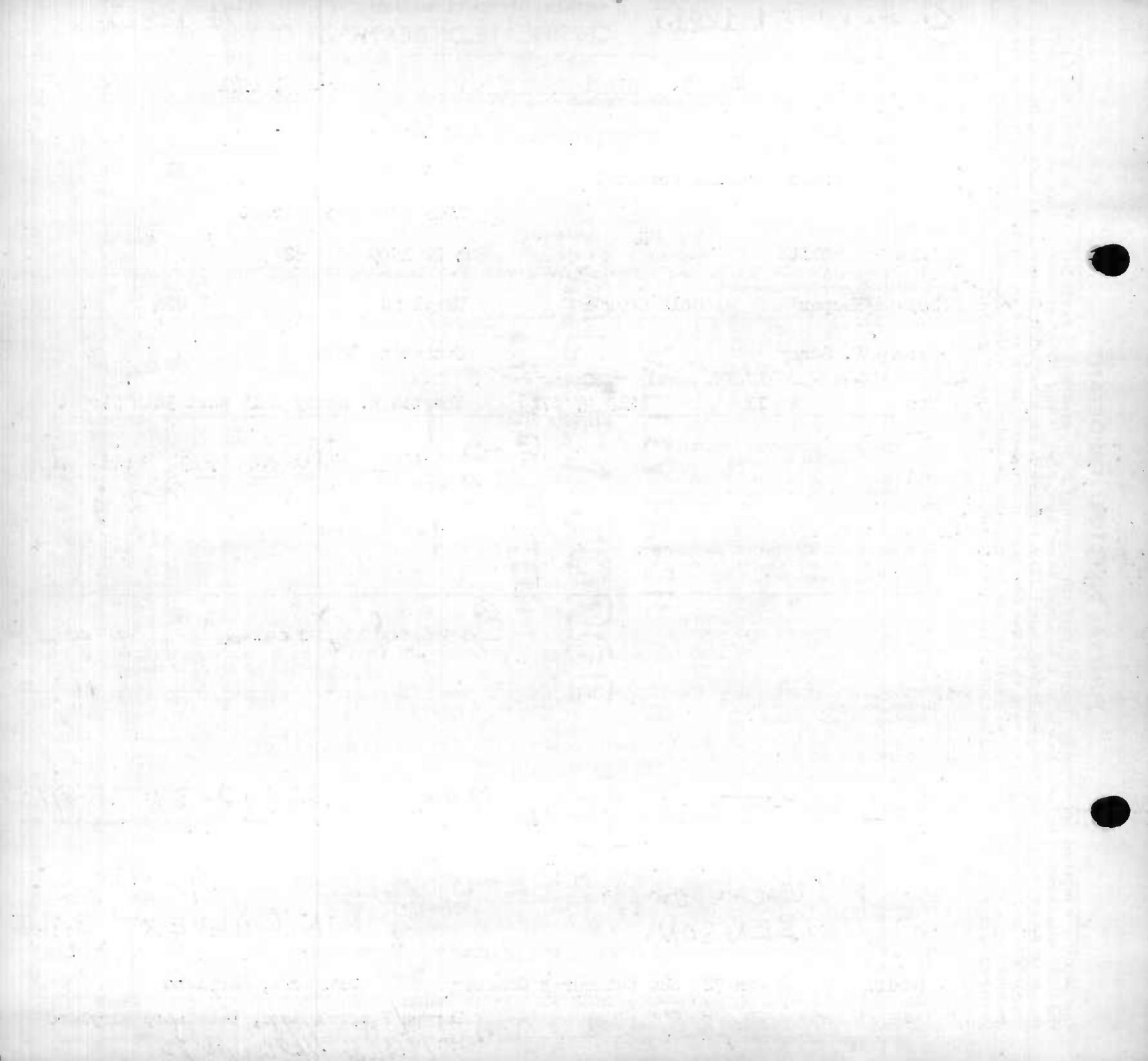
B-263		71 12214		BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO. 71 12214	
1. NAME OF DECEASED (Type or Print)		John C. Richards, Sr.		2. DATE AND HOUR OF DEATH December 31 1971		10 <sup>30</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2714		5. SEX Male		6. RACE White	
FULL NAME OF HOSPITAL OR INSTITUTION  4301 Falls Road		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5 1881		9. AGE (In years lost birthday) 90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10B. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Richards		14. MOTHER'S MAIDEN NAME —		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 32 7145	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT Edgar A. Richards 4324 Falls Road		19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  (If In Baltimore City, give exact location)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 1961 Dec 31 1971 to Dec 31 1971		22. I certify that (I) (this hospital) attended the deceased from Dec 31 1971 to Dec 31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.		23A. SIGNATURE William G. Helfrich	
23B. DATE SIGNED 3 January 72		23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich		23D. ADDRESS 5006 Roland Avenue		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 5 Jan 72		24C. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cemetery		24D. LOCATION Carroll County, Maryland		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR R. J. G. & CO.		25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland		ADDRESS	
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-500 BIRTH NO.		71 12215	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12215
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH		
LEO T. GANEY		2. DATE AND HOUR OF DEATH December 31 1971 10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307		
FULL NAME OF HOSPITAL OR INSTITUTION  44 Union Memorial Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1015 West 38th Street				
S. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22 1909	9. AGE (in years lost birthday) 62 If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greens Keeper		10B. KIND OF BUSINESS OR INDUSTRY Golf Course		
13. FATHER'S NAME George T. Ganey		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		14. MOTHER'S MAIDEN NAME Catherine Shea		
16. SOCIAL SECURITY NO. 219 07 8716		17. INFORMANT ADDRESS Theetta K. Ganey 1015 West 38th Street		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Coronary thrombosis minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stalling the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) 2 Previous M.I.'s DUE TO, OR AS A CONSEQUENCE OF:  (C) Emphysema years		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7-12 1966 to 12-31 1971, shot (I) (we) last saw the deceased alive on 11-16 1971 and shot in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W.P. Benson, Jr. M.D. DEGREE		23B. DATE SIGNED 1-3-72		
23C. PHYSICIAN'S NAME (Type) WBENSON		23D. ADDRESS 3506 N. CALVERT BALT MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 Jan 72		24C. NAME OF CEMETERY or CREMATORIUM New Cathedral Cemetery
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert L. Tolson, Jr.		25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland
ADDRESS By: Harold H. Murray				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K.340		71 12216	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	X REG. NO. 71 12216
BIRTH NO.				2. DATE AND HOUR OF DEATH DEC. 30, 1971 9 15 P.M.	
1. NAME OF DECEASED (Type or Print) TODD ALLEN KEITHLEY				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		A. STATE MD. HARFORD		B. COUNTY HARFORD 6200	
FULL NAME OF HOSPITAL OR INSTITUTION INSTITUTION		C. CITY OR TOWN HAYRE de GRACE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. ADDRESS OR LOCATION SOUTH BALTIMORE GEN. HOSPITAL		E. STREET AND NUMBER RD# 2 Box 207			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 - 9 - 64	9. AGE (In years last birthday) 7	If Under 1 Yr. Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS E. KEITHLEY		14. MOTHER'S MAIDEN NAME ELIZABETH Mc MILLEN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown! If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. Thomas E. KEITHLEY	
18. <del>324</del> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		ADDRESS WEBSTER VILLAGE RD # Box 207	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTICEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) since the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: SEVERE DIFFUSE PNEUMONIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF: SPASTIC PARAPLEGIA 2° TO PREVIOUS ENCEPHALITIS PSYCHOMOTOR RETARDATION			
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC. 28 1971 to DEC. 30 1971 that (I) (we) last saw the deceased alive on DEC. 30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson R. de Lara		DEGREE		23B. DATE SIGNED DEC. 30, 1971	
23C. PHYSICIAN'S NAME (Type) NELSON R. DE LARA		DEGREE		23D. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/1972		24C. NAME OF CEMETERY OR CREMATORIUM ANGEL Hill CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert S. Talley, M.D.		25C. FUNERAL DIRECTOR (Signature) Jerry Harde Grace, M.D.	
VS 150-REV. 1/1/68					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460 71 12217

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

71 12217

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Raymond B. Miller

2. DATE AND HOUR OF DEATH

December 30, 1971

1:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4204 Roland Avenue

Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES

NO

2714

E. STREET AND NUMBER

4204 Roland Avenue 21211

5. SEX

Male

6. RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Sep 12, 1896

9. AGE (In years  
last birthday)

75 yrs.

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Professor

10B. KIND OF BUSINESS OR INDUSTRY

University

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H. Miller

14. MOTHER'S MAIDEN NAME

Brownell

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary O. Miller 4204 Roland Ave. 21211

ADDRESS

18. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE CVA  
DUE TO, OR AS A CONSEQUENCE OF:

2 yrs

(B) Hypertension & SCVD  
DUE TO, OR AS A CONSEQUENCE OF:

2.5 yrs

(C).

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

NO

(If in Baltimore City, give exact location)

MEDICAL CERTIFICATION

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED  
While At Work  Not While At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

7/2/45 19 to 12/30/71 19

that (I) (we) last saw the deceased alive on

12/29/71 19

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francis W. Gluck

DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

12/31/71

23C. PHYSICIAN'S  
NAME (Type)

Francis W. Gluck

DEGREE

23D. ADDRESS

100W University PKwy

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation 1/3/72

24C. NAME of CEMETERY or CREMATORIUM

Green Mount Cemetery

24D. LOCATION  
(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

25B. NAME OF REGISTRAR

Robert J. Gluck

25C. FUNERAL DIRECTOR

Dondvan Funeral Home 3818 Roland Ave.

ADDRESS

1000 ft. = 300 m.

100

1000 ft. = 300 m.

1000 ft. = 300 m.

1000 ft. = 300 m.  
1000 ft. = 300 m.

1000 ft. = 300 m.

1000 ft. = 300 m.

100

100

1000 ft. = 300 m.

100

1000 ft. = 300 m.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-200 BIRTH NO.		71 12218	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	REG. NO.	71 12218
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH DECEMBER 31, 1971 8 P.M.				
CATHERINE M SCHUCH						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MARYLAND B. COUNTY 901				
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 533 E. 38th ST.						
5. SEX Female 6. RACE F White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-10-1900 9. AGE (In years lost birthday) 71 10. US Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME JAMES LUNDY		12. CITIZEN OF WHAT COUNTRY? USA				
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No --		16. SOCIAL SECURITY NO. 212-22-7400B		17. INFORMANT Joseph J. Schuch (Husband) Same		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIO RESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) BREAST CANCER				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/4/71 to 12/31/71 that (I) (we) last saw the deceased alive on 12/31/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE De V. M. R.		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. DATE SIGNED (2/31/71)		
23C. PHYSICIAN'S NAME (Type) CESAR VILARDON INTERN		23D. ADDRESS 33rd and Colvert ST.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens Cockeysville, Md.		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972 Robert E. Seitz M.D.		25B. NAME OF REGISTRAR C O N		25C. FUNERAL DIRECTOR Eugenia K. Seitz ADDRESS Seitz Funeral Home 5209 York Rd. Balto.		
VS 150-REV. 1/1/68						



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

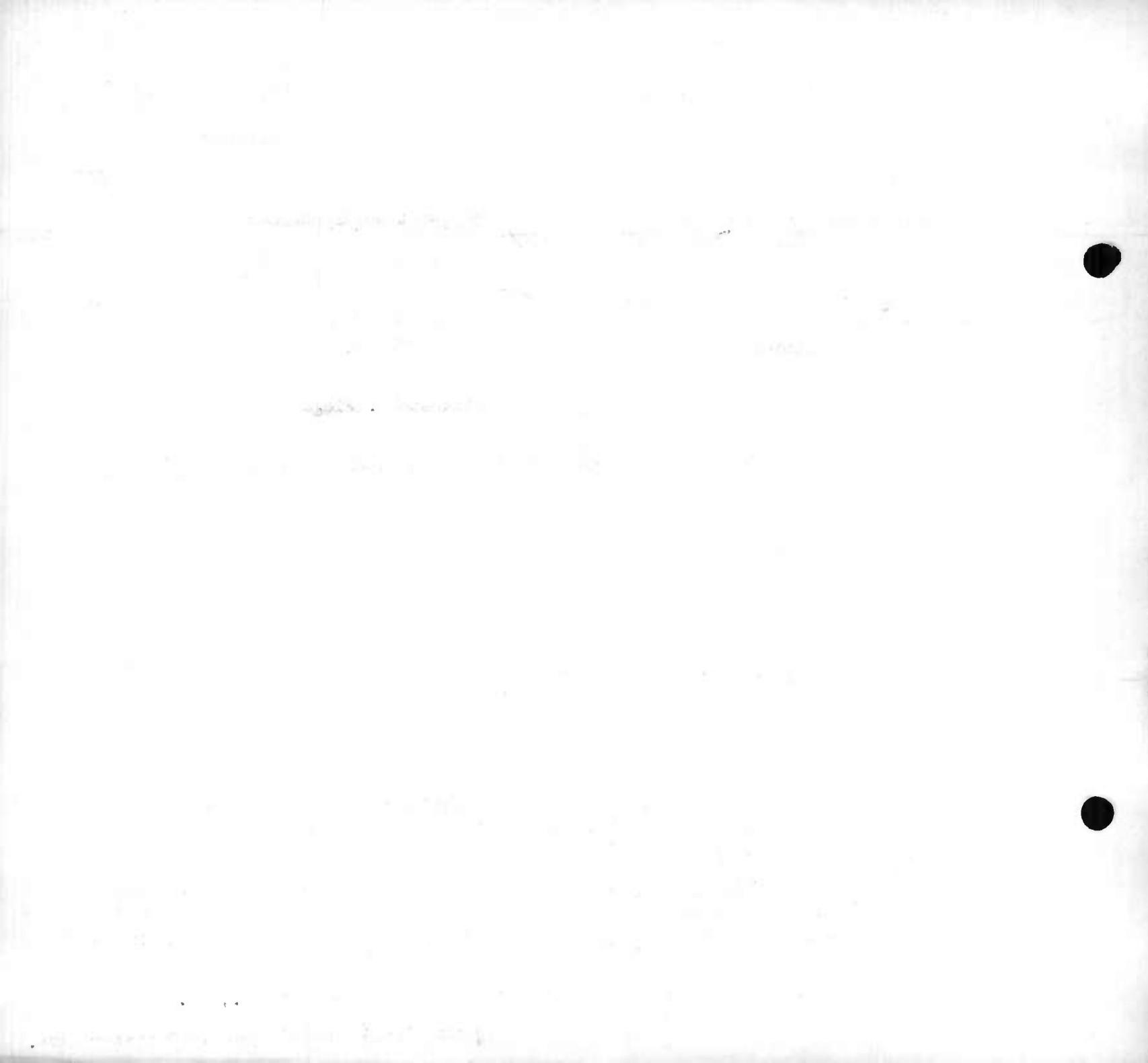
W-46		71 12219		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12219	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		E DNA M. WILBUR		2. DATE AND HOUR OF DEATH DEC 31, 1971 1435 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  UNIVERSITY OF MARYLAND 38				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MD B. COUNTY BALTIMORE CITY 2402			
				C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 401 WARREN AVE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEM	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-98		9. AGE (in years last birthday) 73	11. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  II		20. INFORMANT Mrs. Mary R. McHugh 1520 Northbourne Road 21212		ADDRESS  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
21A. MEDICAL CERTIFICATION DATE OF OPERATION 19A. DATE OF OPERATION 010/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPERIATED VISCUS		20A. AUTOPSY? (Yes or No) YES NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from DEC 1 19 71 to DEC 31 19 71 that (1) (we) last saw the deceased alive on DEC 31 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anthony J. Raneri MD		23B. DATE SIGNED Dec 31, 1971					
23C. PHYSICIAN'S NAME (Type) ANTHONY J. RANERI MD		23D. ADDRESS 225. GREENE ST BALTIMORE, MD					
24A. FUNERAL CREMATION, REMOVALS (Specify) Barigal		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery		24D. LOCATION (City, town, or county) Baltimore City, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 1 1972		25B. NAME OF REGISTRAR R. C. R. A. D.		25C. FUNERAL DIRECTOR McGly Funeral Homes 130 E. Fort Ave 21230		ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burn; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

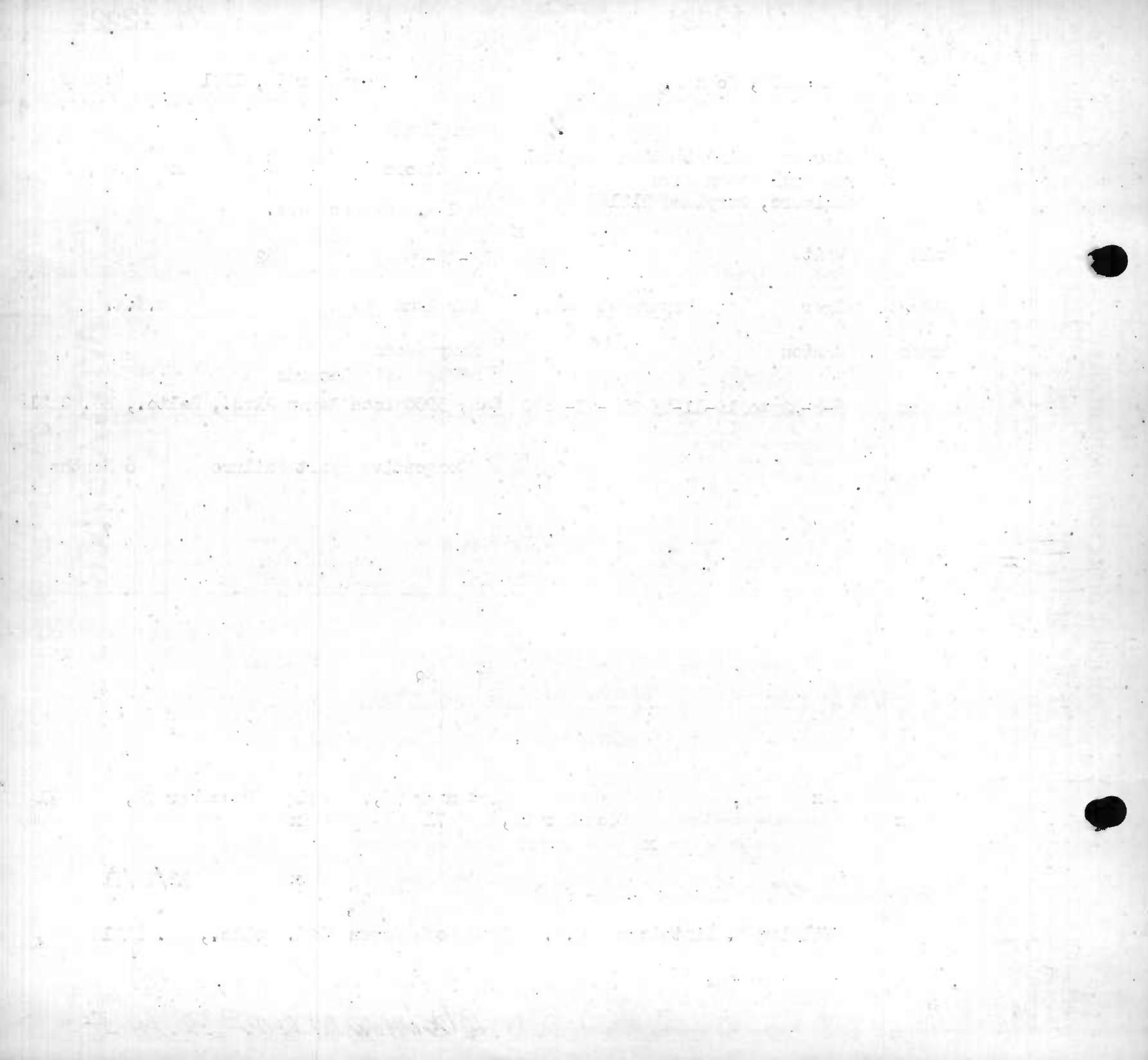
7-200 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12220
1. NAME OF DECEASED (Type or Print) FIEGE, Charles		2. DATE AND HOUR OF DEATH 12/31/71 1145 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  CORANADA NURSING CENTER 4017 L. Beatty Hsgts Ave		4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. SEX Male 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-69 9. AGE (in years last birthday) 52 II Under 3 Yrs. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-3403		17. INFORMANT Elizabeth M. Fiege Same
18. 412-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		ADDRESS  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:		
21A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ that (I) (we) last saw the deceased alive on 12/31/71 19_____ and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		8/25/71 19 to 12/31/71 19		
23A. SIGNATURE		23B. DATE SIGNED 11/1/72		
23C. PHYSICIAN'S NAME (Type) Hollis Seunarine		23D. ADDRESS 1801 Gwynnway Rd Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Valley, X.D.		25C. FUNERAL DIRECTOR Brzdzinski Funeral Home 1407 Eastern Ave.
VS 150-REV. 1/1/68				ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-550		71 12221	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12221
BIRTH NO.		2. DATE AND HOUR OF DEATH December 28, 1971		4:50 P M.	
1. NAME OF DECEASED (Type or Print) <b>MANNION, John F.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 23 3900 Loch Raven Blvd Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>602</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-09</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restraunt</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James J. Mannion</b>		14. MOTHER'S MAIDEN NAME <b>Mary Woods</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>5-4-42 to 10-11-45 214-01-5620</b>	17. INFORMANT <b>VAH, 3900 Loch Raven Blvd., Balto., Md. 21218</b>		ADDRESS
18. <b>412-41</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last.		(B) <b>ASCVd</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>12/27/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  (If In Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>December 27, 1971</b> to <b>December 28, 1971</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>December 28, 1971</b> and that in <b>(I)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) <b>not</b> <b>allow</b> view the body after death.					
23A. SIGNATURE  <i>William R. Linthicum M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>William R. Linthicum M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Blvd. Balto., Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-3-72</b>	24C. NAME OF CEMETERY or CREMATORIAL <b>New Cathedral Crem.</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1972 Robert E. Barber, M.D.</b>		25B. NAME OF REGISTRAR <b>0 0 0</b>		25C. FUNERAL DIRECTOR <b>R. Bobb 1906 Sat 28 1972 E. B. 4 To. St.</b>	ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600		71 12222		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12222	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		Louis E Bauer				2. DATE AND HOUR OF DEATH			
						29 Dec 1971 2:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)				A. STATE Springfield		B. COUNTY CAROLINA	
University of Maryland Hospital						C. CITY OR TOWN Sykesville MD		D. INSIDE CITY LIMITS?	
						E. STREET AND NUMBER		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/96		9. AGE (in years lost birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATIENT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Bauer				14. MOTHER'S MAIDEN NAME Catherine Bach					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-56-3472		17. INFORMANT CHART		ADDRESS			
18. 576991		CAUSE OF DEATH		MYOCARDIAL Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/24/71			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE CARDIAC Arrest					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				Respiratory Arrest					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (After stating the UNDERLYING CONDITION last.)				(B) DUE TO, OR AS A CONSEQUENCE OF:					
UNDERLYING CONDITION last.				(c) Aspiration					
II				Gas hemothorax Bleeding		9-16-71			
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12/23/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G.I. Bleeding		20A. AUTOPST? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (he) (this hospital) attended the deceased from 22 Dec 1971 to 29 Dec 1971 that (we) last saw the deceased alive on 29 Dec 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jerome Koeppel MD		23B. DATE SIGNED 29 Dec 1971							
23C. PHYSICIAN'S NAME (Type) Jerome Koeppel MD		23D. ADDRESS University of Maryland Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORY New Cemetery		24D. LOCATION (City, town, or county) Old Frederick Road Baltimore			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert Saben MD		25C. FUNERAL DIRECTOR Maurice J. Murphy		ADDRESS 1216 S Charles St			

adm. 2/6/26

100% postural  
2012 w/ 100% postural

## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460

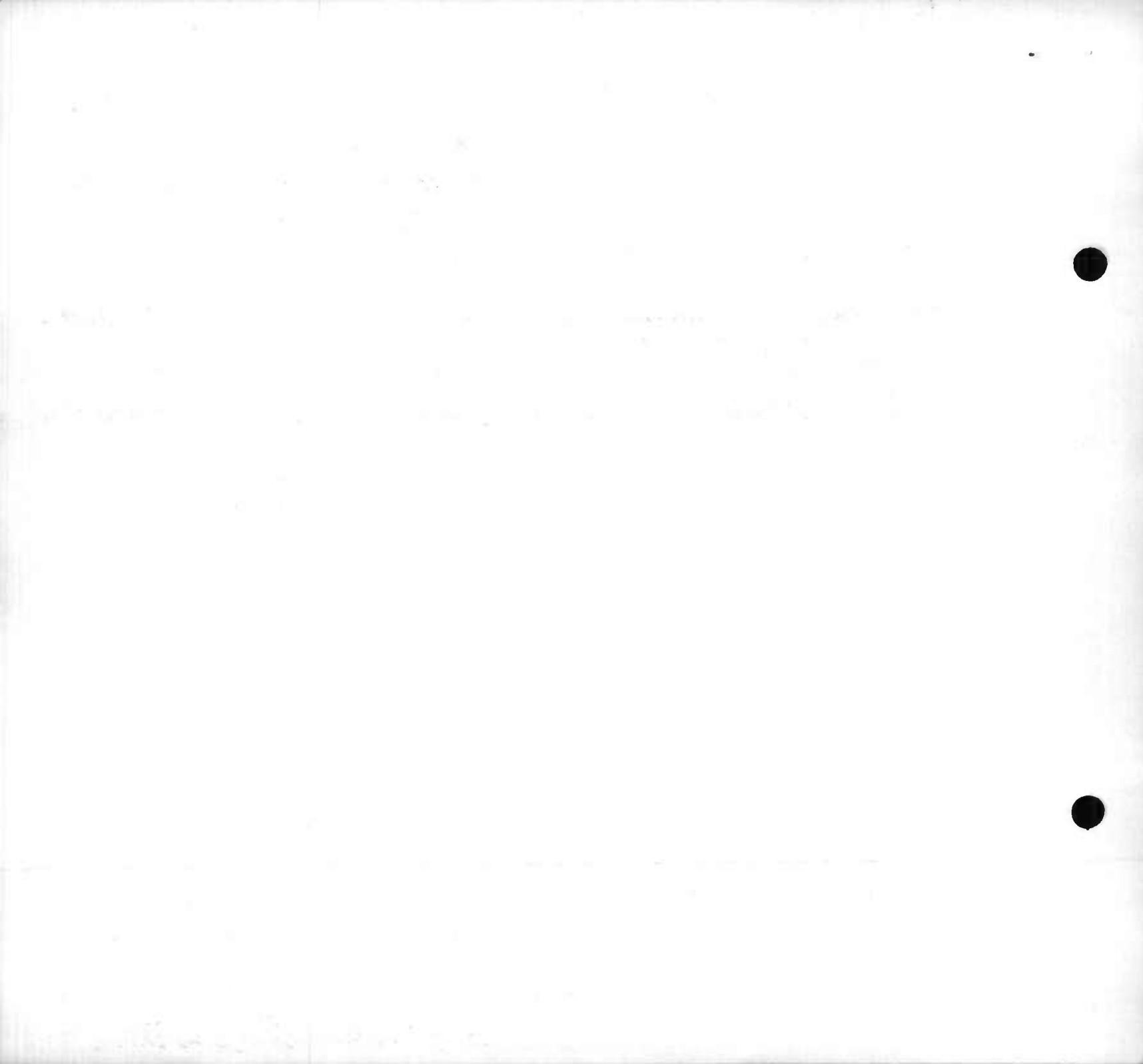
71 12223

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

71 12223

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
THERESA A. TAYLOR		DEC 30 1971 4:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
48 Md. General Hospital		A. STATE Md.	B. COUNTY Baltimore 5300
5. SEX <input checked="" type="checkbox"/> F		6. RACE <input checked="" type="checkbox"/> W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Food & Bed. Adams.	8. DATE OF BIRTH 11/21/71
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		9. AGE (in years last birthday) 50	10. Under 1 To Months 11. Under 24 Hrs. Days 12. Under 24 Hrs. Hours Min.
13. FATHER'S NAME Alfred Waldrighi		14. MOTHER'S MAIDEN NAME Pearl (Unknown)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Type, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-1439	17. INFORMANT Lawrence E. Taylor
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Pulmonary Nekrosis DUE TO, OR AS A CONSEQUENCE OF Breast Carcinoma	
19. ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1967 - 1971			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-25 1971 to DEC 30 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC 30 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.			
23A. SIGNATURE Elma M. O.		Attending Phys. <input type="checkbox"/> Degree	23B. DATE SIGNED DEC 30, 1971
23C. PHYSICIAN'S NAME (Type) BAYANI S. ELMA M. O.		23D. ADDRESS 5355 Conway St. Balt. Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/3/72	24C. NAME OF CEMETERY or CREMATORIUM Glenwood Cemetery	24D. LOCATION (City, town, or county) Elmwood, A. T. Md. (State)
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR I. Y. L. U. S. S.	25C. FUNERAL DIRECTOR Singleton Funeral Home Cemetery	ADDRESS 1010 Garrison Avenue, Baltimore, Md.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

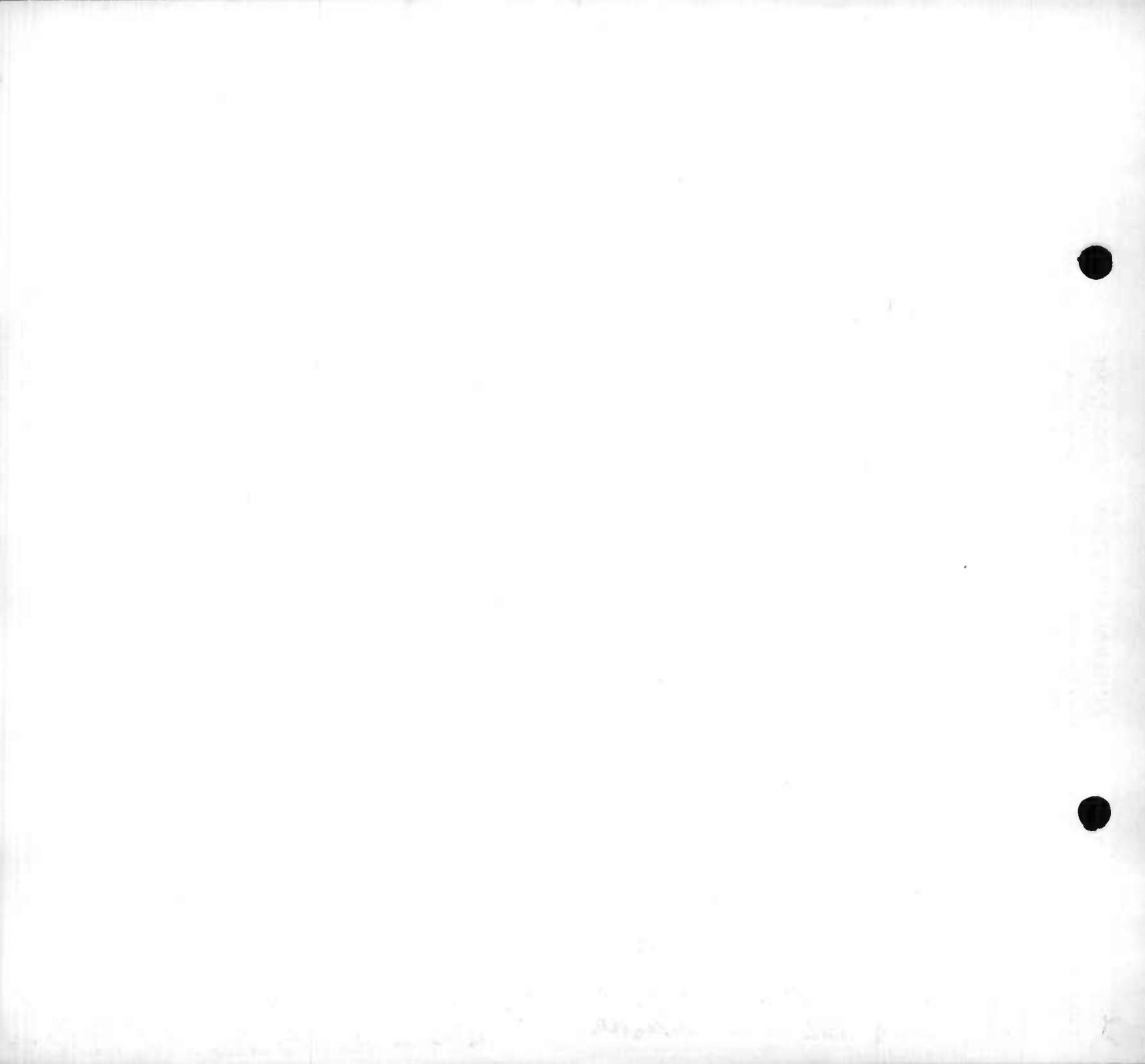
B-650 BIRTH NO. 1. NAME OF DECEASED (Type or Print)		71 12224 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12224 M.	
LOUISE BROWN		2. DATE AND HOUR OF DEATH 12/31/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 2005 Dennison St OO		4. USUAL RESIDENCE (Where deceased lived. II institution; residence before admission) A. STATE Md B. COUNTY 1506			
C. CITY OR TOWN Baltimore E. STREET AND NUMBER 2005 Dennison St		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 81	If Under 1 Yr. Months Days Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Mary's County, Md	
13. FATHER'S NAME ????		14. MOTHER'S MAIDEN NAME Alice		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Holly 3717 Ferndale Ave	
18. 412-3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH		ADDRESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (Cerebral Hemorrhage)		(B) Arterio-sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: Arterio-sclerotic Heart Disease		(C) Arterio-sclerotic Heart Disease Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If In Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/30/71 to 12/31/71 that (I) (we) last saw the deceased alive on 12/30/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward E. Holt, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/3/72	
23C. PHYSICIAN'S NAME (Type) Edward E. Holt, M.D.		23D. ADDRESS 3715 Liberty Heights Ave.			
24A. BURIAL CREMATION, DATE REMOVAL (Specify) Burial 1/5/72		24C. NAME OF CEMETERY OR CREMATORIUM Mt Calvary Cemetery		24D. LOCATION (City, town, or county) AA County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972 Robert E. Halstead, M.D.		25B. NAME OF REGISTRAR O O O		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	
ADDRESS VS 150-REV. 1/1/68					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<span style="font-size: 2em; font-weight: bold;">B-400</span> <span style="font-size: 1.5em;">71 12225</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		<span style="font-size: 1.5em;">71 12225</span> REG. NO.	
1. NAME OF DECEASED <small>(Type or Print)</small> <span style="font-size: 1.2em;">THERESA BEALL</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">DOROTHY 12-29-71</span>		<span style="font-size: 1.2em;">5:40 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <small>(If not in hospital or institution, give street address or location)</small> <span style="font-size: 1.2em;">49 NORTH CHARLES GENERAL HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTO 5300</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span> 6. RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">11-17-27</span> 9. AGE (in years lost birthday) <span style="font-size: 1.2em;">44</span>	If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span> 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">HENRY BIELAMOWICZ</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">AMELIA BRZOSTEK</span>			
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) If yes, give war or dates of service</small>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-24-0738</span>		17. INFORMANT <span style="font-size: 1.2em;">PA HOSPITAL RECORD</span> <small>ADDRESS</small>	
18. <span style="font-size: 1.2em;">194X</span> I <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small>		<b>CAUSE OF DEATH</b> <small>(A) IMMEDIATE CAUSE METASTATIC CA OF DUE TO, OR AS A CONSEQUENCE OF: <i>breast</i></small>		<small>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</small>	
<b>ANTECEDENT CAUSES</b> <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last.</small>		<small>(B) DUE TO, OR AS A CONSEQUENCE OF:</small>			
<b>II</b> <small>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</small>		<small>(C) _____</small>			
<b>MEDICAL CERTIFICATION</b> 19A. DATE OF OPERATION <span style="font-size: 1.2em;">12-13-71</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">ADRENALECTOMY FOR CA OF BREAST</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">—</span>		21C. WHERE DID INJURY OCCUR? <span style="font-size: 1.2em;">—</span> <small>(If in Baltimore City, give exact location)</small>	
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">—</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-9-71</span> to <span style="font-size: 1.2em;">12-29-71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-29-71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;"><i>A. Carangal</i></span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/29/71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">TEODORO CARANGAL</span>		23D. ADDRESS <span style="font-size: 1.2em;">NORTH CHARLES GENERAL HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1-3-72</span>		24C. NAME OF CEMETERY OR CREMATORIY <span style="font-size: 1.2em;">Holy Rosary Cem.</span>	
25A. DATE REC'D BY HEALTH DENT. <span style="font-size: 1.2em;">JAN 4 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. E. Valles, R.D.</span>		24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Dundalk, BALTO MD</span> <small>(State)</small>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John W. McElroy &amp; Sons Inc. S. Chester</span>		ADDRESS <span style="font-size: 1.2em;">401</span>			
<small>VS 150-REV. 1/1/68</small>					



## BALTIMORE CITY HEALTH DEPARTMENT

71 12226

BIRTH NO.

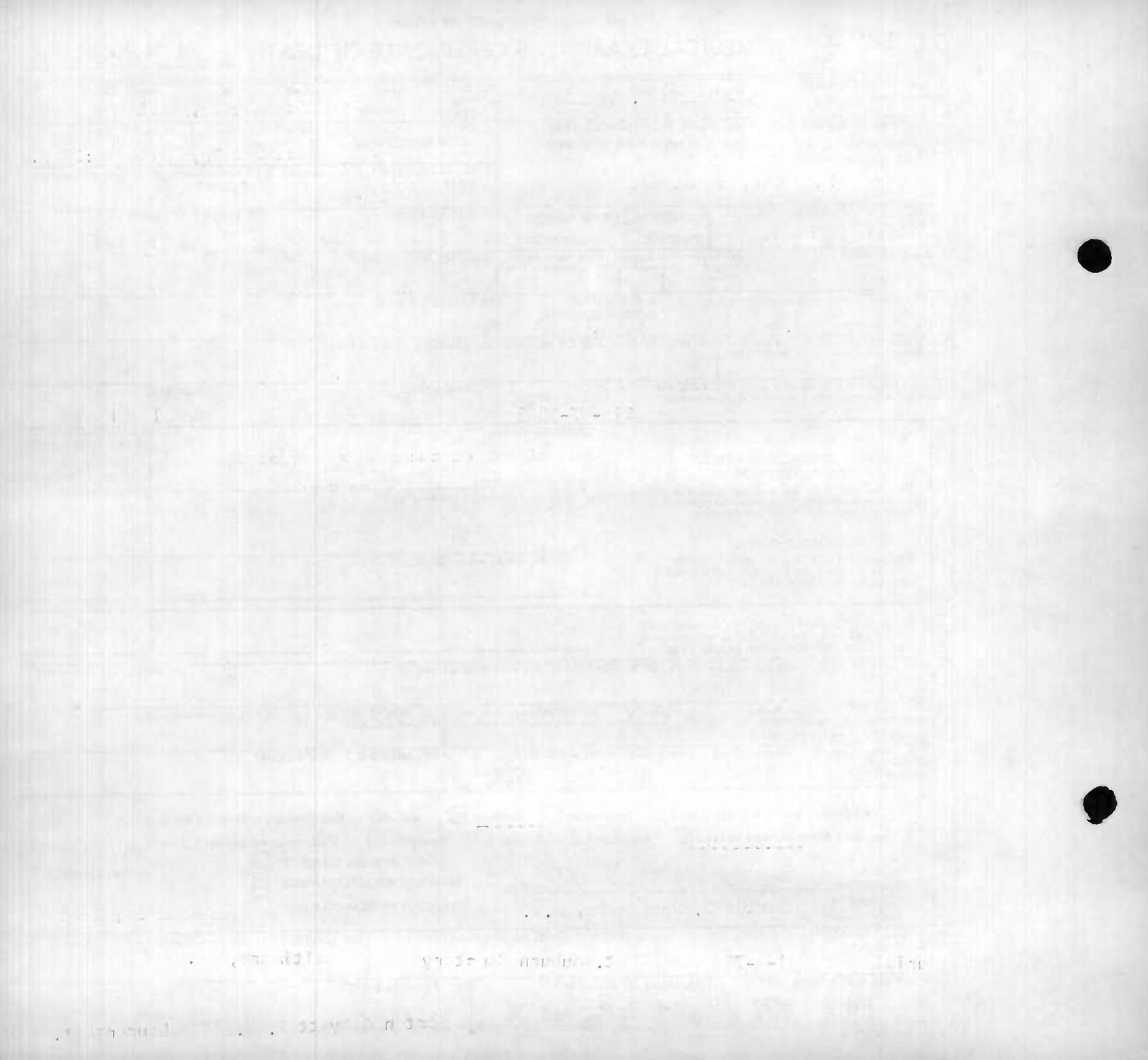
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12226

E 152

A 520

1. NAME OF DECEASED (Type or Print)		CATHERINE M. EVANS (Ames		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month December 29, 1971 Estimated <input type="checkbox"/> Day Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  1346 Division Street				3. DATE PRONOUNCED DEAD Month Day Year	Hour
6. SEX Female		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702	
9. DATE OF BIRTH 11-7-14		10. AGE (In years lost birthday) 57	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		E. STREET AND NUMBER 1346 Division Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Annie L. Ames	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 215-07-3583		18. INFORMANT James Evans Sr. 1346 Division	
19. 153.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carcinoma of cecum with perforation and (A) IMMEDIATE CAUSE peritonitis DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 30, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-72	24C. NAME of CEMETERY or CREMATORIUM Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) Baltimore, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens St.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12227	
1. NAME OF DECEASED (Type or Print) EDGERTON MARY m. (Burley)		2. DATE AND HOUR OF DEATH December 31, 1971 6:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIV. of MD HOSP. 22 S GREENE ST BALTO. MD		4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE Md. B. COUNTY 1901			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 308 N. Carey St.					
5. SEX F.	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-1908	9. AGE (in years lost birthday) 63	10. KIND OF BUSINESS OR INDUSTRY
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Powellsburg, N.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS Deceased EVER in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service	
				16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION listed.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		17. INFORMANT Jerome Burley 308 N. Carey St.	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Oscillated CVA		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
		(C) Hyper cardio vascular disease, CHF		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
19A. MEDICAL CERTIFICATION DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input type="checkbox"/> (this hospital) attended the deceased from December 19 1971 to December 31 1971 that <input type="checkbox"/> (I) <input type="checkbox"/> (we) last saw the deceased alive on December 31 1971 and that in <input type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) <input type="checkbox"/> (We) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Robert P. Whitehead M.D.		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23C. DATE SIGNED December 31, 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 1-4-72		24C. NAME OF CEMETERY OR CREMATORIAL Carver Mem. Pk.		24D. LOCATION (City, town, or county) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Morton B. Dyett, F.H. M.D. - Laurens	
ADDRESS					
VS 150-REV. 1/76					



D 250

71 12228

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12228

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Dixon, Jr.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*78*  
Maryland General Hospital(If not in hospital or institution, give street  
address or location)

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 9. DATE OF BIRTH

2-5-61

10. AGE (In years  
lost birthday)

10

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

## 14B. KIND OF BUSINESS OR INDUSTRY

Child

## 15. MOTHER'S MAIDEN NAME

Mamie Buriss

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Child

## 17. SOCIAL SECURITY NO.

Child

## 18. INFORMANT

Charles Dixon

## ADDRESS

## MEDICAL CERTIFICATION

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,

heart failure, asthma, etc. It means the disease,

injury or complication which caused death.)

injury or complication which caused death.)

## ANTECEDENT CAUSES

## DISEASES OR CONDITIONS, IF ANY, GIVING

RISE TO THE ABOVE CAUSE (A) STATING THE

UNDERLYING CONDITION LAST.

UNDERLYING CONDITION LAST.

## II

## OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE TERMINAL

DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

Yes

## 22A. EXTERNAL CAUSE WAS

UNDERLYING  OR CONTRIB-UTING  CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., In or about

home, farm, factory, street, office bldg., etc.)

Unknown

## 22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

Unknown

## 22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY (APPROX.) unk. 1965

WHILE AT WORK NOT WHILE AT WORK 

## 22E. INJURY OCCURRED

Unknown

## 22F. HOW DID INJURY OCCUR?

Unknown

## 23.

I certify that I held an Inquiry  Inspection  Autopsy resulted from: Natural causes  Accident Suicide  Homicide  Undetermined manner Deputy CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

1-1-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

1-4-72

## 24C. NAME of CEMETERY or CREMATORI

Mt. Calvary Cemetery

## 24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

## 25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1972

## 25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

## 25C. FUNERAL DIRECTOR

Morton &amp; Dyett F. H. 1701 Laurens St.

## ADDRESS

N 854.0

VS 151-REV. 1/1/68



**FUNERAL DIRECTOR: IMPORTANT**

S-351  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
71 12229		CERTIFICATE OF DEATH		71 12229	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>ROSCOE STANFIELD</b>		12/31/71 1 430 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  UNIV OF MD. HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY BALTO CITY 1603 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1105 N. FULTON AVE 21217			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/19	9. AGE (in years last birthday) 52	10. IF Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME PRESTON STANFIELD		14. MOTHER'S MAIDEN NAME ELLA FULLER 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. —			
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		17. INFORMANT LILLIE STANFIELD ADDRESS 18 PRESSSBURG ST. BALTO, MO APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ≈ 20 yrs			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		(A) IMMEDIATE CAUSE CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) PNEUMONIA			
20A. DATE OF OPERATION 3/12/23		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene (R) leg	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Dec. 27 1971 to Dec. 31 1971 that (I) (we) last saw the deceased alive on Dec. 31, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Kenneth V. Eden MD		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) KENNETH V. EDEN M.D.		23D. ADDRESS UNIV. HOSP. BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 1-5-72 Mt. Auburn Cem.		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE	24D. LOCATION (City, town, or county) BALTIMORE, MD.	(State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Sabby, M.D.	25C. FUNERAL DIRECTOR Morton & Deyett F.H.	ADDRESS 1701-A Laurens St.	



## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

31 12230

BIRTH NO

1. NAME OF DECEASED (Type or Print)		Annie Darby		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month Estimated <input type="checkbox"/> 12	Day 31	Year 71	Hour 8:25 P.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD	Month 12	Day 31	Year 71	Hour 8:25 P.M.		
		Bon Secours Hospital								
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE	Maryland		2002			
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		
9. DATE OF BIRTH		10. AGE (In years last birthday)		If Under 1 Yr. <input type="checkbox"/> Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	E. STREET AND NUMBER					
4-22-22		49			2140 W. Baltimore St.					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME
George Town, S. C.		U. S. A.		Joseph Nelson		n/a			n/a	Carolina Nelson
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS				
n/a				John Darby 2140 W. Baltimore St.						
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease								
		(B) DUE TO, OR AS A CONSEQUENCE OF:								
		(C)								
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)				
						No				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?						
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT <input type="checkbox"/> m. NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?						
23.										
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)				Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 1-1-72	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORIAL		24D. LOCATION (City, town, or county)		(State)		
Burial		1-5-72		Mt. Auburn Cemetery		Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR					ADDRESS	
JAN 4 1972 Robert E. Farber, M.D.									Morton & Dyett F. H. 1701 Laurens St.	

11 - 2 - 7

11 - 7

11 - 1 - 2

11 - 2

32-12-44 dr

**FUNERAL DIRECTOR: IMPORTANT**

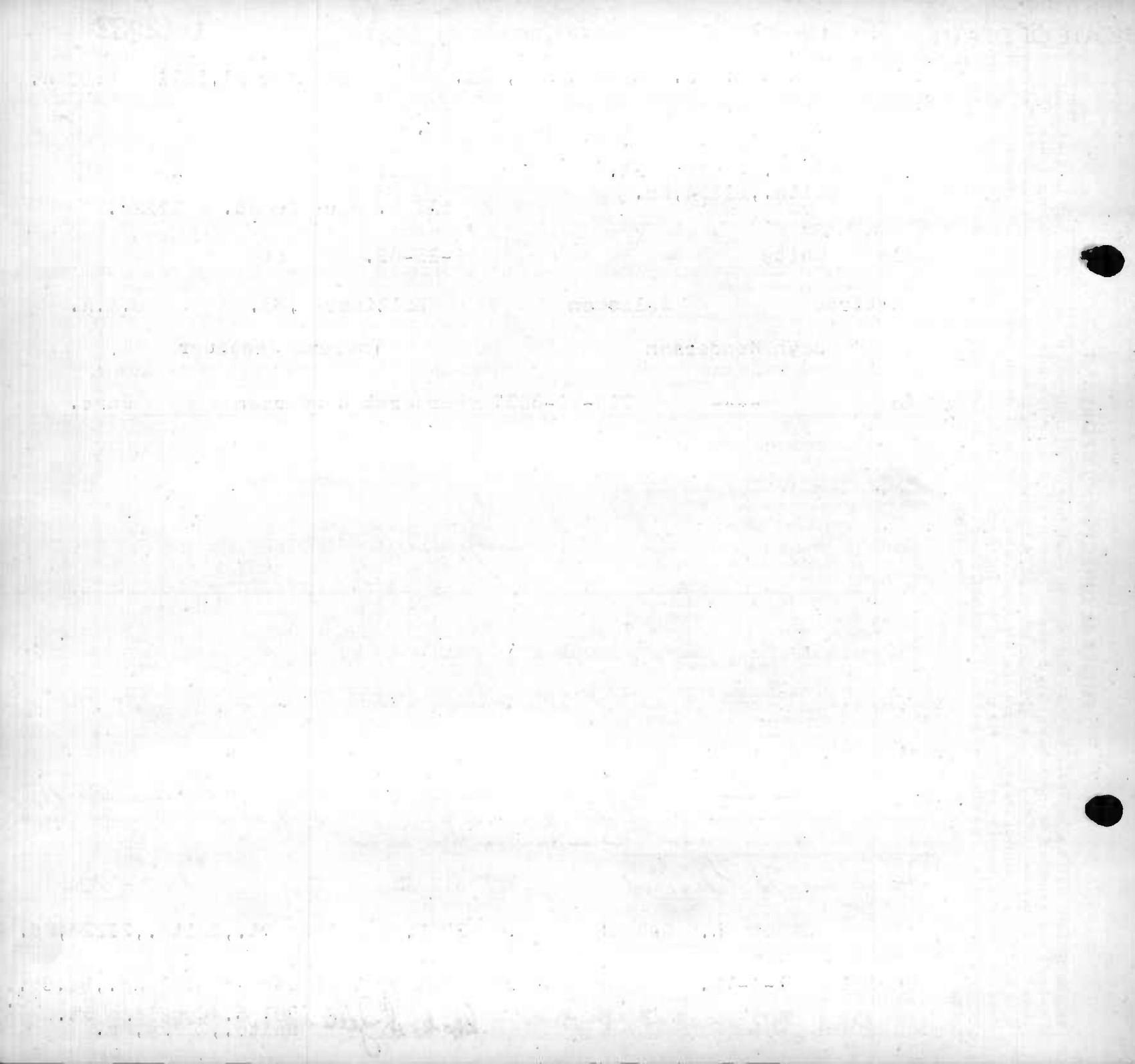
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X REG. NO. 71 12231													
BIRTH NO. 71 12231													
1. NAME OF DECEASED (Type or Print) Nettie Faulcon (NETTIE FAULCON)		2. DATE AND HOUR OF DEATH 12/28/71 6-22 P.M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals			A. STATE Maryland			B. COUNTY Baltimore							
4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
E. STREET AND NUMBER 210 Center Street													
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-1867		9. AGE (in years lost birthday) 104		II Under 1 Yr. Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) North Carolina, Halifax		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Byrd						14. MOTHER'S MAIDEN NAME Minerva Byrd							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO.			17. INFORMANT 4940 Eastern Avenue BOH: RECORDS Baltimore, Maryland 21224							
18. I CAUSE OF DEATH APPROXIMATE INTERVAL DISEASE OR CONDITION DIRECTLY BETWEEN ONSET AND DEATH LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (IA) slowing the UNDERLYING CONDITION lost.													
(A) IMMEDIATE CAUSE CARDIOPULMONARY ARREST 2-3 hrs. DUE TO, OR AS A CONSEQUENCE OF:													
(B) ATERIOSCLEROTIC HEART DISEASE 7/10 yrs. DUE TO, OR AS A CONSEQUENCE OF:													
(C) _____													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from 4/12/71 to 12/28/71 that (I) (we) last saw the deceased alive on 12/28/71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.													
23A. SIGNATURE Smart S. W. S. M.D.						23B. DATE SIGNED 12/28/71							
23C. PHYSICIAN'S NAME (Type) SURAT SWASA, M.D.		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland BALTIMORE CITY HOSP. 21224		DEGREE									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-72		24C. NAME OF CEMETERY or CREMATORIAL Carters Temple Cemetery		24D. LOCATION Littleton, North Carolina		(City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1972		25B. NAME OF REGISTRAR Robert E. Jaibey, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens St.		ADDRESS							

100% 100% 100% 100%

100% 100% 100% 100%





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

X-200 BIRTH NO.		71 12233		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12233	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
KOBERT J. KOCH, Jr.		12. 30. 71					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY		Maryland, Baltimore 5300			
SINAI HOSPITAL OF BALTIMORE INC. BELVEDERE AT GREENSPRING.		C. CITY OR TOWN D. INSIDE CITY LIMITS?		Reisterstown BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5. 21. 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOLBOY		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years lost birthday) 5		If Under 1 Yr. Months: Days: Hours: Min.	
13. FATHER'S NAME ROBERT KOCH, Jr.		11. BIRTHPLACE (State or foreign country) MARYLAND Delaware		12. CITIZEN OF WHAT COUNTRY U.S.A.			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		14. MOTHER'S MAIDEN NAME BETTY Williams		ADDRESS SINAI HOSPITAL BELVEDERE AT GSPRING	
18. <u>284X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIOPULMONARY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CNS BLEEDING</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>APLASTIC ANAEMIA</u>		1 hr. 2 yrs 9 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 16m</u> 19 <u>71</u> to <u>Dec 30th</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Dec 28m</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.							
23A. SIGNATURE <u>Angela white</u>		23B. DATE SIGNED <u>12. 30. 71</u>					
23C. PHYSICIAN'S NAME (Type) <u>DR. ANGELA WHITE.</u>		23D. ADDRESS SINAI HOSPITAL BELVEDERE AT GREENSPRING					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY OR CREMATORIUM Sylvan Lawn Cem.		24D. LOCATION (City, town, or county) Greene, Clarendon, New York	
25A. DATE REC'D BY HEALTH DEPT. JAN 1 1972		25B. NAME OF REGISTRAR Patsy E. Barber, M.D.		25C. FUNERAL DIRECTOR Edmund Owings Mills, Ltd.		ADDRESS	
VS 150-REV. 1/1/68							

Small white bird

Small white bird

Small white bird

Small white bird

White

Small white bird and small white bird  
and small white bird

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-632 71 12234

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12234

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES BRADSHAW

2. DATE AND HOUR OF DEATH

12-29-71 9:45 pm

P

M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
*38*

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNIVERSITY OF  
MD. HOSPITAL

5. SEX

M

6. RACE

N

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)

A. STATE

B

B. COUNTY

MARYLAND

1801

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER

919 W. LEXINGTON ST.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Bradshaw

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service

Yes W.W. 2

16. SOCIAL SECURITY NO.

316-18-4094

CAUSE OF DEATH

8. DATE OF BIRTH

11/21/33

9. AGE (in years  
lost birthday)

48

If Under 1 Yr.  
Months Days Hours  
II Under 24 Hrs.  
Min.

11. BIRTHPLACE (State or foreign country)

Baltimore MD.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Ethel Bishop

17. INFORMANT

WIFE Mable Bradshaw Same

ADDRESS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF:

IMMED

(B) CIRCULATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF:

8 1/2 hr.

(C) GASTRO-INTESTINAL BLEED

3 wks.

MEDICAL CERTIFICATION

21A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work  Not While At Work

22. I certify that (I) (this hospital) attended the deceased from 12-29-71 to 12-29-71  
that (I) (we) last saw the deceased alive on 12-29-71 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert A. Lessey

Attending  
Phys.  
Degree

Med.  
Director  
Staff  
Phys.

23B. DATE SIGNED

12-29-71

23C. PHYSICIAN'S  
NAME (Type)

ROBERT A. LESSEY

23D. ADDRESS

U. MD. HOSPITAL. DENT MED.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY

CREMATORY

24D. LOCATION

(City, town, or county) (State)

25A. DATE RECEIVED BY HEALTH DEPT.

25B. DATE REGISTRATION

25C. FUNERAL DIRECTOR

ADDRESS



1  
M243

71 12235

BALTIMORE CITY HEALTH DEPARTMENT

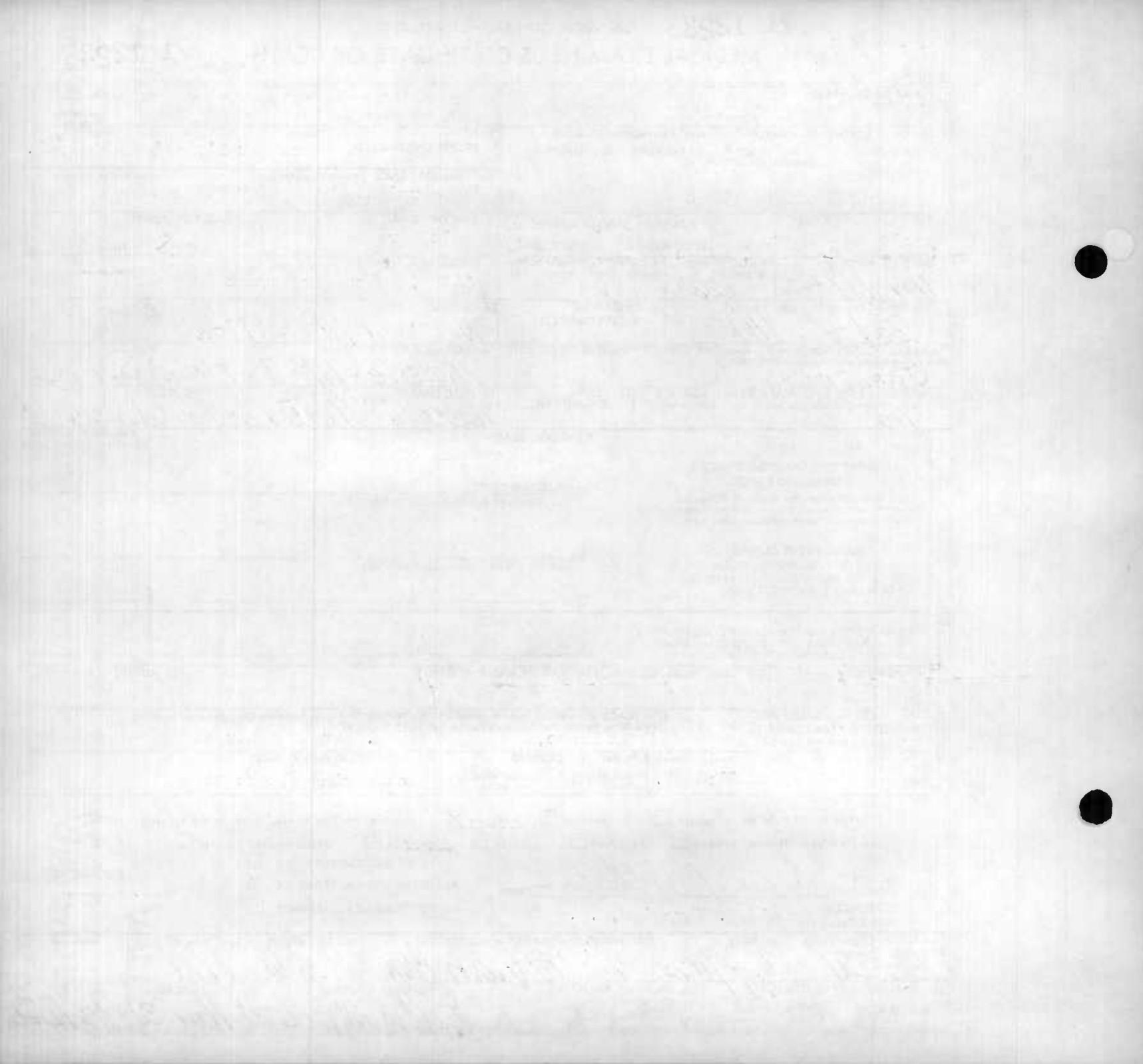
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12235

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		IRENE McGLOTTON		2. DATE OF DEATH	Known <input type="checkbox"/> Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Estimated <input type="checkbox"/>				M.
		UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD	Month	Day	Year	Hour
6. SEX		7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN	D. INSIDE CITY LIMITS?			
Female		Negro		Baltimore	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		
9. DATE OF BIRTH		10. AGE (In years lost birthd.)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER				
Nov. 11, 1945		26		247 N. Schroeder Street				
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME				
B.C. 1961				William J. McGlotton				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME				
Salesperson				Mable (Mc)Glotton Spriggs				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT	ADDRESS			
No				Mable J. McGlotton	247 N. Schroeder St.			
19. E 965X		CAUSE OF DEATH Gunshot wound of chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)				
2				yes				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
		In house		865 W. Saratoga Street				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation				
12-30-71 11:45 P.M.								
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		<i>Ronald N. Kornblum, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORIAL	24D. LOCATION (City, town or county)	(State)			
Burial		1/4/1972	Williams Cem.	Baltimore	Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	ADDRESS			
JAN 4 1972		Robert L. Johnson, Jr.		Williams Funeral Home	3197 Harford Rd.			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-255		71 12236	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12236
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Dec. 31, 1971 19:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 604			
FULL NAME OF HOSPITAL OR INSTITUTION  00 1905 McElderry St. Baltimore, Md. 21205		C. CITY OR TOWN Baltimore (City)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1889 9. AGE (in years last birthday) 82 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME David Heller		14. MOTHER'S MAIDEN NAME Anna C. Schmidt.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-2740		17. INFORMANT Gary S. Hill, 1907 McElderry St., ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
19. ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolus		(B) Fracture, Right Hip DUE TO, OR AS A CONSEQUENCE OF:  (C) Hypertension Years	
20. MEDICAL CERTIFICATION  I certify that the deceased was in regular attendance on the deceased prior to death.		20A. DATE OF OPERATION Dec. 17, 1971 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx. of Right Hip		20A. AUTOPSY? (Yes or No) To be performed 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) 604	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Home.		21C. WHERE DID INJURY OCCUR? 1905 McElderry St., Baltimore	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX) Dec 15, 1971		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. fell in bedroom.	
22. I certify that (I) (we) attended the deceased from December 15, 1971 to December 31, 1971 Johns Hopkins Hospital that (I) (we) last saw the deceased alive on December 30, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary S. Hill, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec. 31, 1971	
23C. PHYSICIAN'S NAME (Type) Gary S. Hill, M.D.		23D. ADDRESS 1907 McElderry St., Baltimore 21205			
24A. BURIAL CREMATION, DATE REMOVAL (Specify) BURIAL JAN 4 1972		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE BALTIMORE CEMETERY		24D. LOCATION BALTO, MD 21213 (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DERT. JAN 4 1972		25B. NAME OF REGISTRAR Valene E. Jaeger, M.D.		25C. FUNERAL DIRECTOR ADDRESS Eleazar Powers House, BALTO, MD 21202	



1 L-526 71 12237 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12237

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		PETER JOSEPH LONCAREVICH, Jr.		2. DATE OF DEATH	Known <input type="checkbox"/> Month Dec. 29, 1971	Year 1971	Hour 3:00 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Estimated <input checked="" type="checkbox"/>			
		225 E. 25th Street		3. DATE PRONOUNCED DEAD	Month December	Day 30, 1971	Hour 2:15 P.M.
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH Dec. 13, 1918		10. AGE (In years lost birthday) 53	# Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 225 E. 25th Street			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Peter Loncarevich, Sr.	14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter			15. MOTHER'S MAIDEN NAME Mary Lewis
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Unknown	18. INFORMANT George Loncarevich, Lakeland Fla.	ADDRESS			
19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic pancreatitis					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/3/71	24C. NAME OF CEMETERY or CREMATORIY St. Luke's Cemetery	24D. LOCATION (City, town, or county) Cumberland, Md.	(State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971		25B. NAME OF REGISTRAR Robert C. Smith		25C. FUNERAL DIRECTOR William G. Kight	ADDRESS Cumberland, Md.		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-352 BIRTH NO.		71 12238		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. _____		71 12238	
1. NAME OF DECEASED (Type or Print)		GANOUNG, CHARLES ARNOLD		2. DATE AND HOUR OF DEATH DECEMBER 30, 1971, 1:15A.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  40		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		2147 21207					
FULL NAME OF HOSPITAL OR INSTITUTION  ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX MALE 6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06 25 04		9. AGE (In years lost birthday) 67		11. Under 1 Yr. Months Days Hours 12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI DRIVER		10B. KIND OF BUSINESS OR INDUSTRY CAB		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213205744		17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &		ADDRESS			
18. 47231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Pneumia Rt base		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days					
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  ASHD							
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (X) (X) (X) (X) attended the deceased from DECEMBER 28 19 71 to DECEMBER 30 19 71 that (1) (X) last saw the deceased alive on DECEMBER 30 19 71 and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (1) (X) (did) (X) view the body after death.									
23A. SIGNATURE  Dr. Amy J		Attending Phys. <input checked="" type="checkbox"/> Degree:		Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/30/71			
23C. PHYSICIAN'S NAME (Type) ADNAN M. SUNNY.		23D. ADDRESS 1011 FREDERICK RD. BALTIMORE, MD. 21228 Degree:							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 3, 72		24C. NAME OF CEMETERY OR CREMATORIAL Lake View Mem. Cemetery		24D. LOCATION Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Barber, Jr.		25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons Inc.		25D. ADDRESS 301 Frederick Rd. Catonsville, Md.			

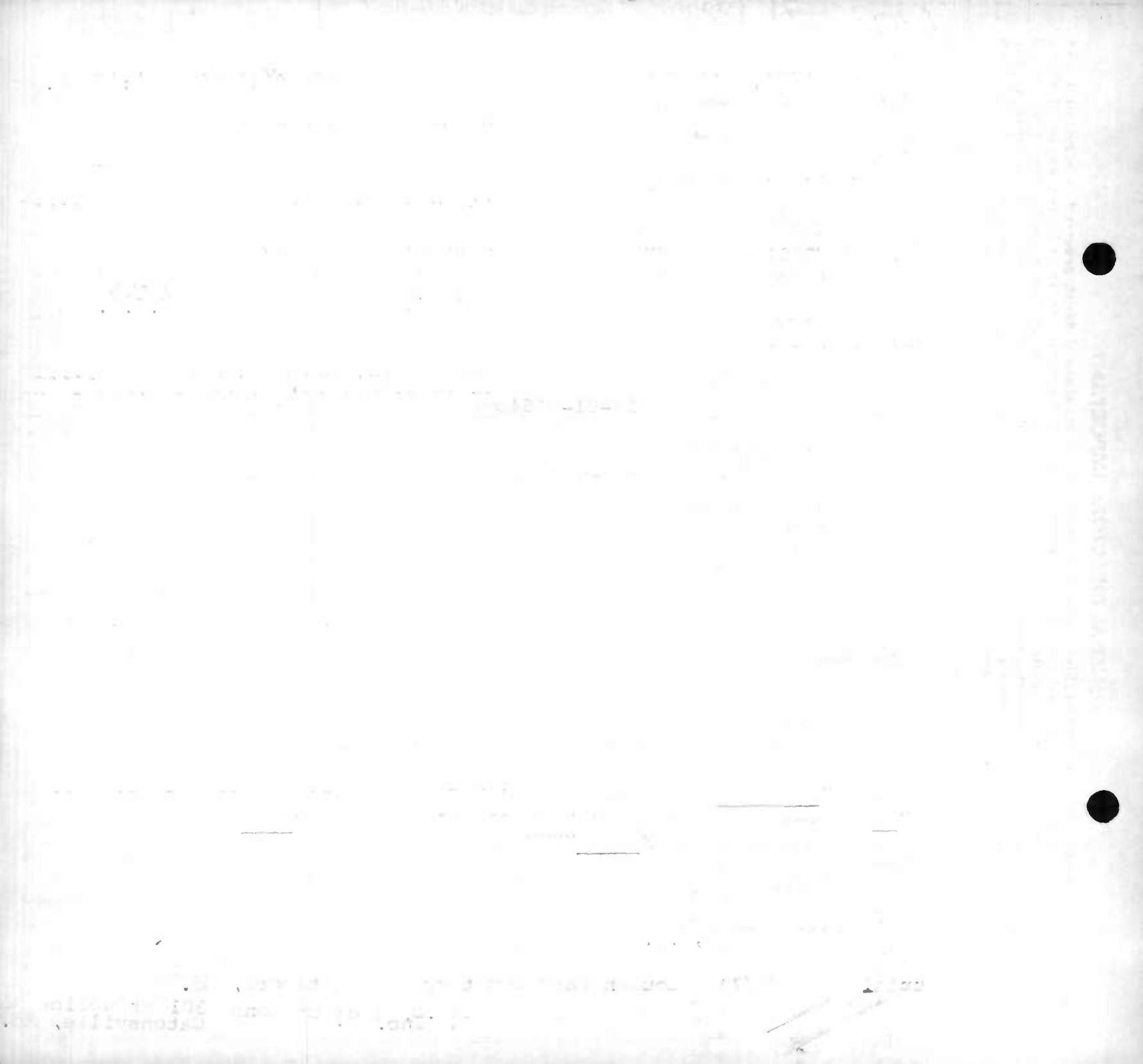
78

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

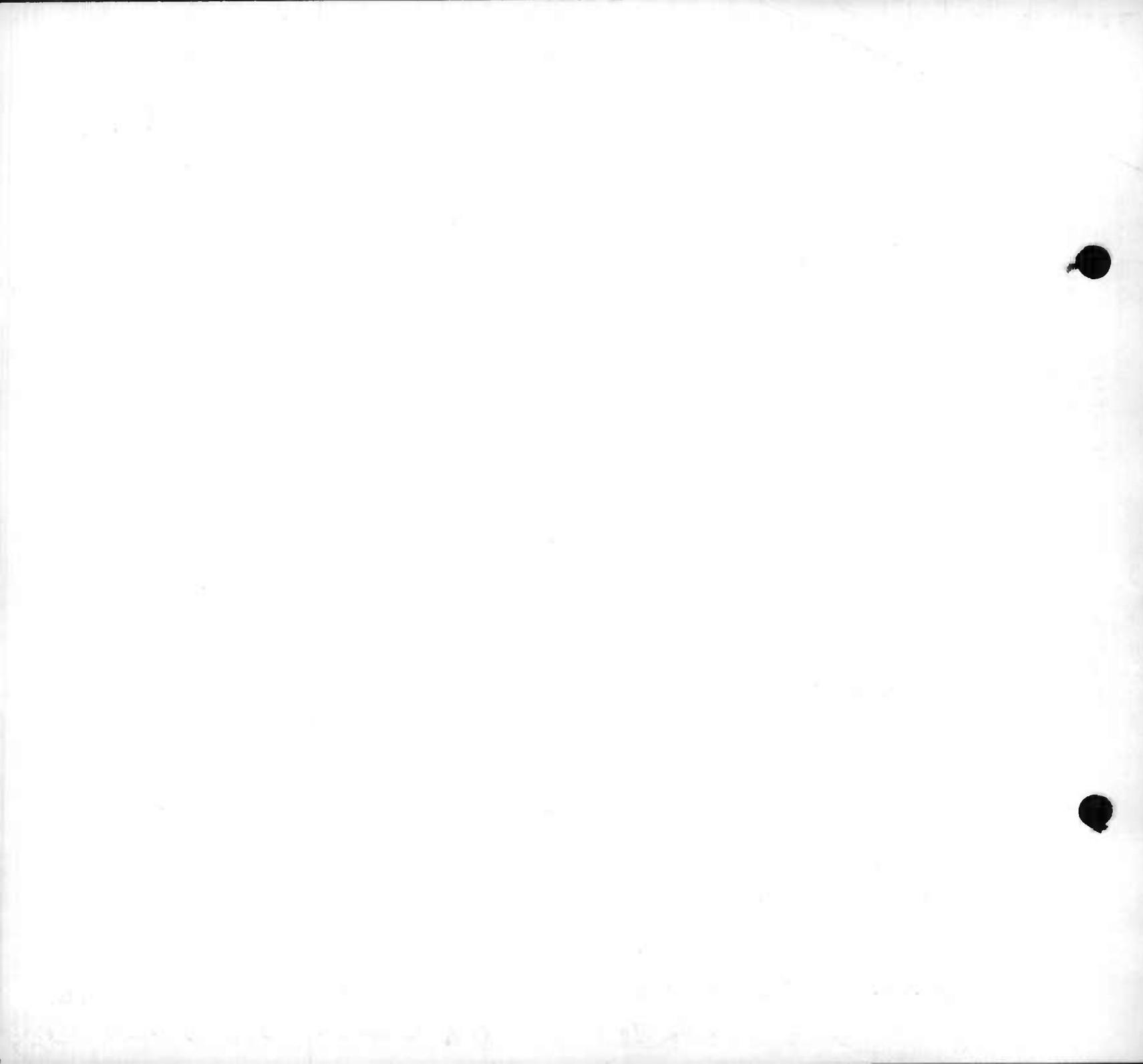
BIRTH NO.		71 12239		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12239	
1. NAME OF DECEASED (Type or Print)		URBE ITUS, MARGARET		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH		DECEMBER 31, 1971 4:45 P. M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)		A. STATE MARYLAND B. COUNTY BALTIMORE 5300	
40 ST AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/04/96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) 75		11. BIRTHPLACE (State or foreign country) MARYLAND	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY WINCES				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-0264		17. INFORMANT BALTIMORE MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. 410.9 1725019		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH Bronchogenic carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
		(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Due to, or as a consequence of: Some due to CVA - Post myocardial infarct		5 days	
		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD - Ostial fibril		5 yrs	
		DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diseases mellitus		7 yrs	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from DECEMBER 27 1971 to DECEMBER 31 1971 that (1) (we) last saw the deceased alive on DECEMBER 31 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE JOSE APTER, M.D.		OEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md. (State)	
Burial JAN 5 1972							
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Vaiden, Jr. D.O.		25C. FUNERAL DIRECTOR Edw. B. MacNabb Sons Inc.		25D. ADDRESS 301 Frederick Rd Catonsville, Md.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-120		71 12240	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12240
BIRTH NO.		2. DATE AND HOUR OF DEATH 0627 hr 12/24/71			
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md B. COUNTY 2710 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/28	9. AGE (in years last birthday) 43
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the cause of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  Sepsis, septic shock, renal (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Shut down  (B) Enterov - cutaneous fistula DUE TO, OR AS A CONSEQUENCE OF:  (C) Gastro - jejun - colic fistula		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12 Dec 71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastro-entero-colic fistula		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from _____ that (I) (we) last saw the deceased alive on 12/23 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Wensky MD		23B. DATE SIGNED 12/23/71			
23C. PHYSICIAN'S NAME (Type) Robert Wensky MD		23D. ADDRESS Univ. of Maryland Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-27-71		24C. NAME OF CEMETERY or CREMATORIAL Hememory Memorial Park	
24D. LOCATION Lanover				(City, town or county) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Parker, Jr.		25C. FUNERAL DIRECTOR R & R Funeral Ser 3821 14th St. NW Wash DC	
				ADDRESS	



B-653 71 12241  
 BIRTH NO. 66-00027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12241

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month December 30, 1971 Estimated <input type="checkbox"/> Year M.	
Lawrence P. Bryant Jr.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  Provident Hospital		3. DATE PRONOUNCED DEAD Month December 30, 1971 Year Hour 3:15 A.M.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  (DOA)			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 1-2-1966	10. AGE (In years lost birthday) 5	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 3116 Gwynn Falls Parkway	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student	14B. KIND OF BUSINESS OR INDUSTRY Public School	15. MOTHER'S MAIDEN NAME Cynthia McNeil	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO.	18. INFORMANT Mr. Lawrence P. Bryant Sr.	ADDRESS 3116 Gwynns
19. <i>466 X</i>  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Falls Pkwy APPROXIMATE INTERVAL Acute bronchitis and bronchiolitis BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE with early bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:	
  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <i>2</i>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 30, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-4-1972	24C. NAME OF CEMETERY or CREMATORIUM Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972	25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>	25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME	ADDRESS 3035 W. NORTH AV

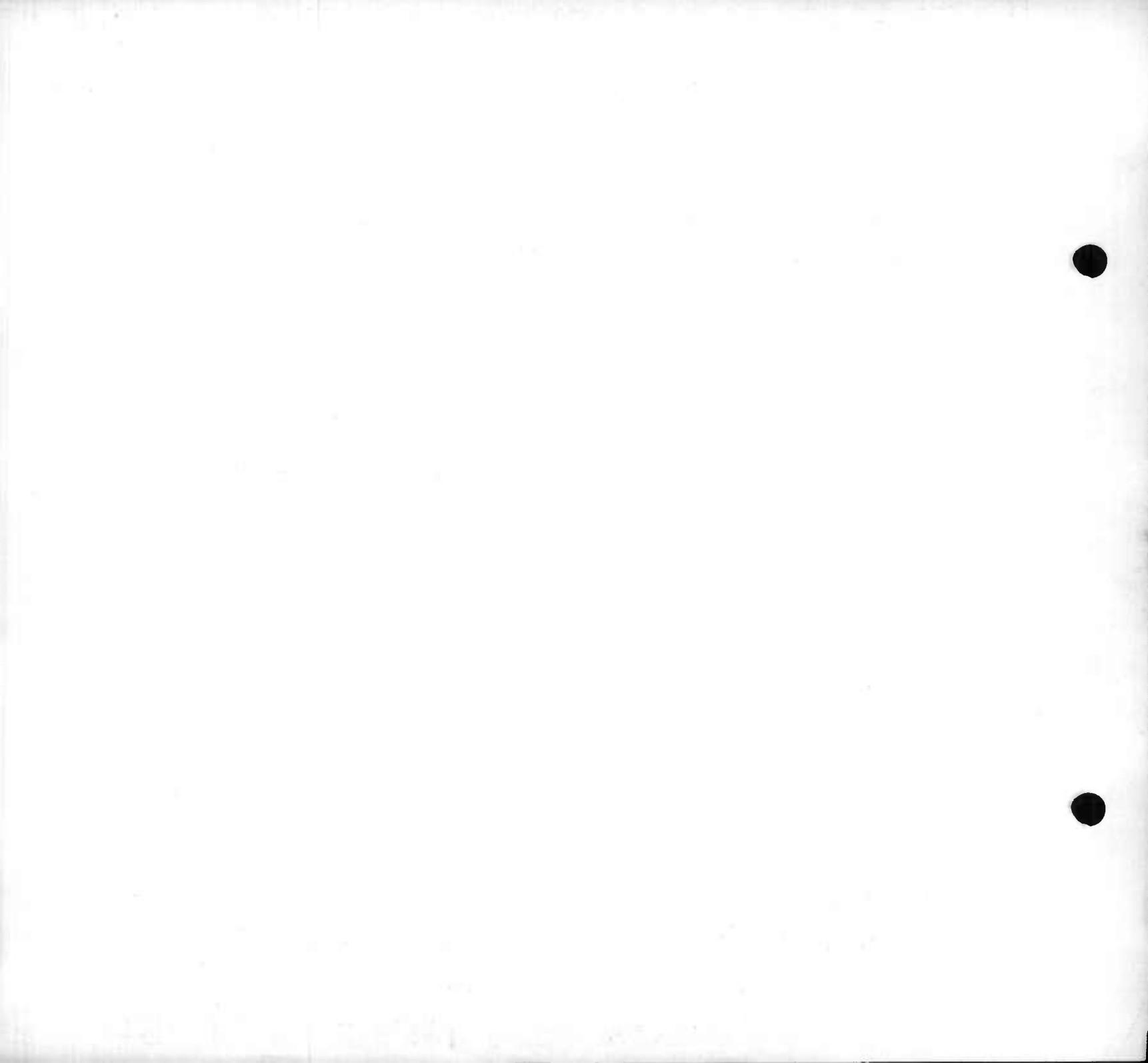
2-9-1972 - Completion of cause of death on a pending medical examiner death certificate.  
C. Springate, M.D.

HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>11-20027</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 12242</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL JONES</u>		2. DATE AND HOUR OF DEATH <u>12/12/71</u>		12:25 P M	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSP</u>  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  A. STATE <u>M.D.</u> B. COUNTY <u>Anne ARUNDA PL 5200</u>			
5. SEX <u>B F</u>		6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>11/29/71</u> 9. AGE (in years last birthday) <u>12</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>LEONA JONES</u>		If Under 1 Yo. Months Days Hours <u>12</u> If Under 24 Hrs. Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>N/A</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>SAME - MAYO POST OFF.</u>	
18. <u>75141</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF:		ADDRESS  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
19. MEDICAL CERTIFICATION  19A. DATE OF OPERATION <u>12/12</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTEST OBSTRUCTION</u>		20A. AUTOPSY? Yes or No <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/29/71</u> , 19 <u>71</u> to <u>12/12/71</u> , 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/12/71</u> , 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mr. Waldman</u>		23B. DATE SIGNED <u>12/12/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Waldman</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-20-71</u>		24B. DATE <u>12-20-71</u>		24C. NAME OF CEMETERY or CREMATORIUM <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley Jr.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-260 71 12243		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12243
BIRTH NO.		2 DATE AND HOUR OF DEATH 12 - 16 - 71 1 - 23 a.m.		
1. NAME OF DECEASED (Type or Print) <b>CARL DOZIER</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL 38 BALTIMORE MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE <b>Rosedale, MARYLAND</b> B. COUNTY <b>5300</b>		
		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER <b>OWINGS MILLS, MARYLAND</b>		
5. SEX <b>M</b> 6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-63</b> 9. AGE (in years lost birthday) <b>8</b> If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN DOZIER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hilary Spence</b> ADDRESS <b>University Hospital</b>
18. <b>343.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>BILATERAL PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SPLASTIC OR ADRIPLEGIA</b>
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ENCEPHALOPATHY SEIZURE DISORDER</b>
				(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				8 yrs.
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that, (I) (this hospital) attended the deceased from <b>12-15-1971</b> to <b>12-16-1971</b> that (I) (we) last saw the deceased alive on <b>12-15-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Hilary Spence</b>		23B. DATE SIGNED <b>12-16-71</b>		
23C. PHYSICIAN'S NAME (Type) <b>HILARY SPENCE</b>		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12-20-71</b>		24C. NAME OF CEMETERY OR CREMATORIUM <b>UNIVERSITY MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) <b>UNIVERSITY MEDICAL SCHOOL</b> (State)
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>DR. E. BAILEY, MD</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCMD</b>
VS 150-REV. 1/1/68				



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71-22043		71 12244		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12244	
CERTIFICATE OF DEATH				2. DATE AND HOUR OF DEATH 12. 3.71 3 <sup>10</sup>			
1. NAME OF DECEASED (Type or Print)		Baby boy Newborn		4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE Md. B. COUNTY 1205			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 Univ. of Md. Hosp		5. SEX M 6. AGE Color		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-71 9. AGE (in years lost birthday) II Under 1 Yrs. Months Days Hours Min. 25	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roberto Wyatt		14. MOTHER'S MAIDEN NAME Mary Newbill		17. INFORMANT ADDRESS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.					
18. 778.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. II means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cardiac arrest Prematurity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF: Prematurity					
		(C) _____					
II OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-3 1971 to 12-3 1971 that (I) (we) last saw the deceased alive on 12-3 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12. 3.71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		ANATOMY BOARD OF MARYLAND			
24A. BURIAL, CREMATION, REMOVAL (Specify) 12-80-71		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE		24D. LOCATION (City, town, or county) UNIVERSITY MEDICAL SCHOOL		(State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972 Robert E. Sabey, M.D.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
				MORTUARY SERVICE - BCBD			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

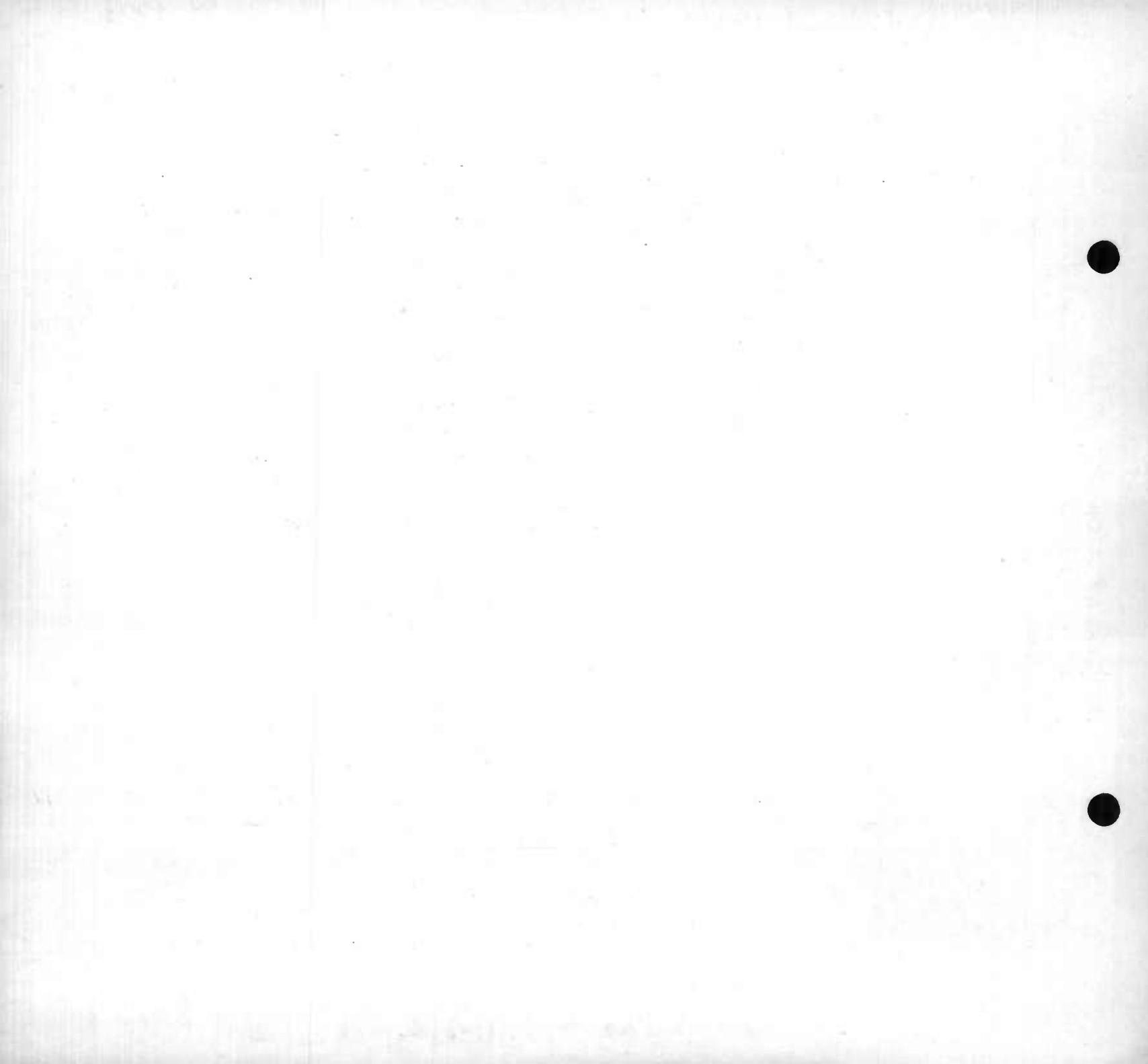
W-300 71 12245		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12245
BIRTH NO. 71-21151		2. DATE AND HOUR OF DEATH 12/18/71 5 30 P M		
1. NAME OF DECEASED (Type or Print) <b>BABY BOY WHITE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIV HOSP</b>		A. STATE <b>MD</b>	B. COUNTY <b>BALTIMORE</b>	C. CITY OR TOWN <b>BALTIMORE</b>
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>929 N. STICKER</b>
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/71</b>	9. AGE (in years last birthday) <b>12923</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>—</b>		14. MOTHER'S MAIDEN NAME <b>CUSSIE WHITE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>MOTHER</b>	ADDRESS
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>PROMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. MEDICAL CERTIFICATION DATE OF OPERATION <b>12/18/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? <b>—</b>	(If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/17/71</b> to <b>12/18/71</b> 1971 to 1971 that (I) (we) last saw the deceased alive on <b>12/18/71</b> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.				
23A. SIGNATURE <b>Mr. Waldman</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>12/18/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALDMAN MR UNIV HOSP</b>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>1-4-72</b>		24B. DATE <b>1-4-72</b>	24C. NAME OF CEMETERY OR CREMATORIA <b>ANATOMY BOARD OF MARYLAND</b>	(State)
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey MD</b>	26. NUMBER OF DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE	
VS 150-REV. 1/1/68				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-240 71 12246		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12246
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/19/71		
1. NAME OF DECEASED (Type or Print) <i>John W. Nicol</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>Long Green Nursing Home. Melrose &amp; Bellona Ave.</i>		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) A. STATE <i>Baltimore, Md.</i> B. COUNTY <i>1401</i>
5. SEX <i>M</i>		6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/22/87</i>
9. AGE (In years last birthday) <i>74</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Accountant, Gas &amp; Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John W. Nicol.</i>		14. MOTHER'S MAIDEN NAME <i>Unknown, Hosler</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-05-4777</i>		17. INFORMANT <i>Wife - 227 W. Lafayette Ave.</i>
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>the</del> hospital) attended the deceased from <i>12/15</i> to <i>12/19</i> , 1971, and that in my ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Norman R. Freeman</i>		23B. DATE SIGNED <i>12/19/71</i>		
23C. PHYSICIAN'S NAME (Type) <i>Norman R. Freeman</i>		23D. ADDRESS <i>11 W. 20th St. Baltimore, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>12-20-71</i>		24B. DATE <i>12-20-71</i>		24C. NAME OF CEMETERY, TOMB, ETC. <i>ANATOMY BOARD OF MARYLAND</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Barber, Jr.</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL</i>
ADDRESS <i>MORTUARY SERVICE - BCID</i>				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-352 71 12247		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12247
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/23/71		8. 110 pm. M. 2744
1. NAME OF DECEASED (Type or Print) <i>Margaret K. Stanis</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)  <i>Montebello State Hospital.</i>		C. CITY OR TOWN Baltimore E. STREET AND NUMBER 3113 Gibbons Ave		
5. SEX <i>female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/93	9. AGE (in years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Taylor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY <i>Lithuania.</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215097602</i>	17. INFORMANT	ADDRESS
18. <i>183.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc., it means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <i>Metastatic Ca of the ovary</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 years</i>
19A. MEDICAL CERTIFICATION DATE OF OPERATION <i>July 1969</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>	20A. AUTOPST? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Cesar L. Gonzalez C. MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 12/23/71	
23C. PHYSICIAN'S NAME (Type) <i>Cesar L. Gonzalez C. MD</i>		ANATOMY BOARD OF MARYLAND INN Halstead Rd. Ap. 2 Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>12-24-71</i>		24B. DATE <i>JAN 5 1972</i>	24C. NAME OF CEMETERY OR CREMATORIUM <i>UNIVERSITY MEDICAL SCHOOL</i>	24D. LOCATION (City, State) <i>Baltimore, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, Jr. MD</i>	25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCBH</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. <span style="float: right;">71 12248</span>				
BIRTH NO. <span style="font-size: 2em; float: left;">L-200</span> 91-32021 12248				2. DATE AND HOUR OF DEATH 12-23-1971										
1. NAME OF DECEASED (Type or Print) <b>Law Boy "A" Gwendolyn</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		7		A M.						
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/71		9. AGE (in years lost birthday) 1 hour				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <b>Bernard</b>		14. MOTHER'S MAIDEN NAME <b>WATS</b> , Gwendolyn												
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue Dr SRABSTEIN		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30'				
19A. DATE OF OPERATION <span style="font-size: 2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)										
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?										
22. I certify that (I) (this hospital) attended the deceased from 12/23/71 19 to 12/23/71 19 shot (I) (we) lost saw the deceased alive on 12/23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <span style="font-size: 2em;"><u>Slichter</u></span>		23B. DATE SIGNED <span style="font-size: 2em;">12/23/71</span>												
23C. PHYSICIAN'S NAME (Type) <b>Dr. Srabstein</b> <span style="font-size: 2em;"><u>DR SRABSTEIN</u></span>		23D. ADDRESS Baltimore City Hospitals-4940 Eastern 5938 E. PRATT ST 21224- Ave.		23E. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										
24A. BURIAL CREMATION, REMOVAL? (Specify) Cremation		24B. DATE 12-27-71		24C. NAME OF CEMETERY or CREMATORIAL Baltimore City Hospitals		24D. LOCATION (City, town, or county) Baltimore, Maryland 21224		(State)						
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Schlesinger		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS								



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12249

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Franklin

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

829 W. Fayette Street

6. SEX  
male7. RACE  
Negro

## 9. DATE OF BIRTH

10. AGE (In years  
last birthday) 74

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19. I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinionresulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12/24/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)24B. DATE  
12/30/7124C. NAME OF CEMETERY or CREMATORIUM  
Mt. Calvary Cemetery24D. LOCATION (City, town, or county)  
A.A. County Maryland

(State)

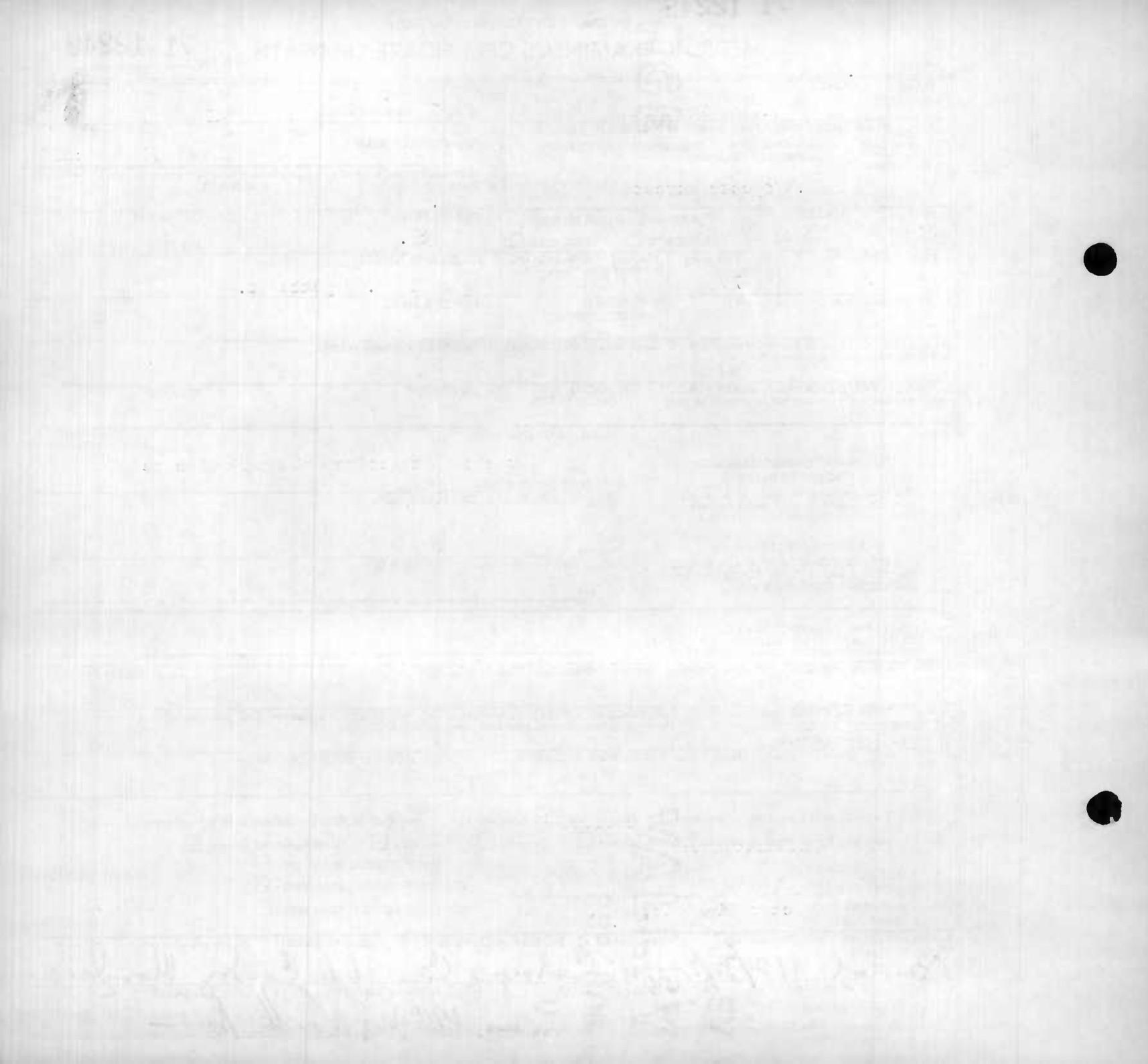
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR  
Robert J. Taffey, R.D.

25C. FUNERAL DIRECTOR

ADDRESS  
1712 W. North Ave

VS 151-REV. 1/1/68



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

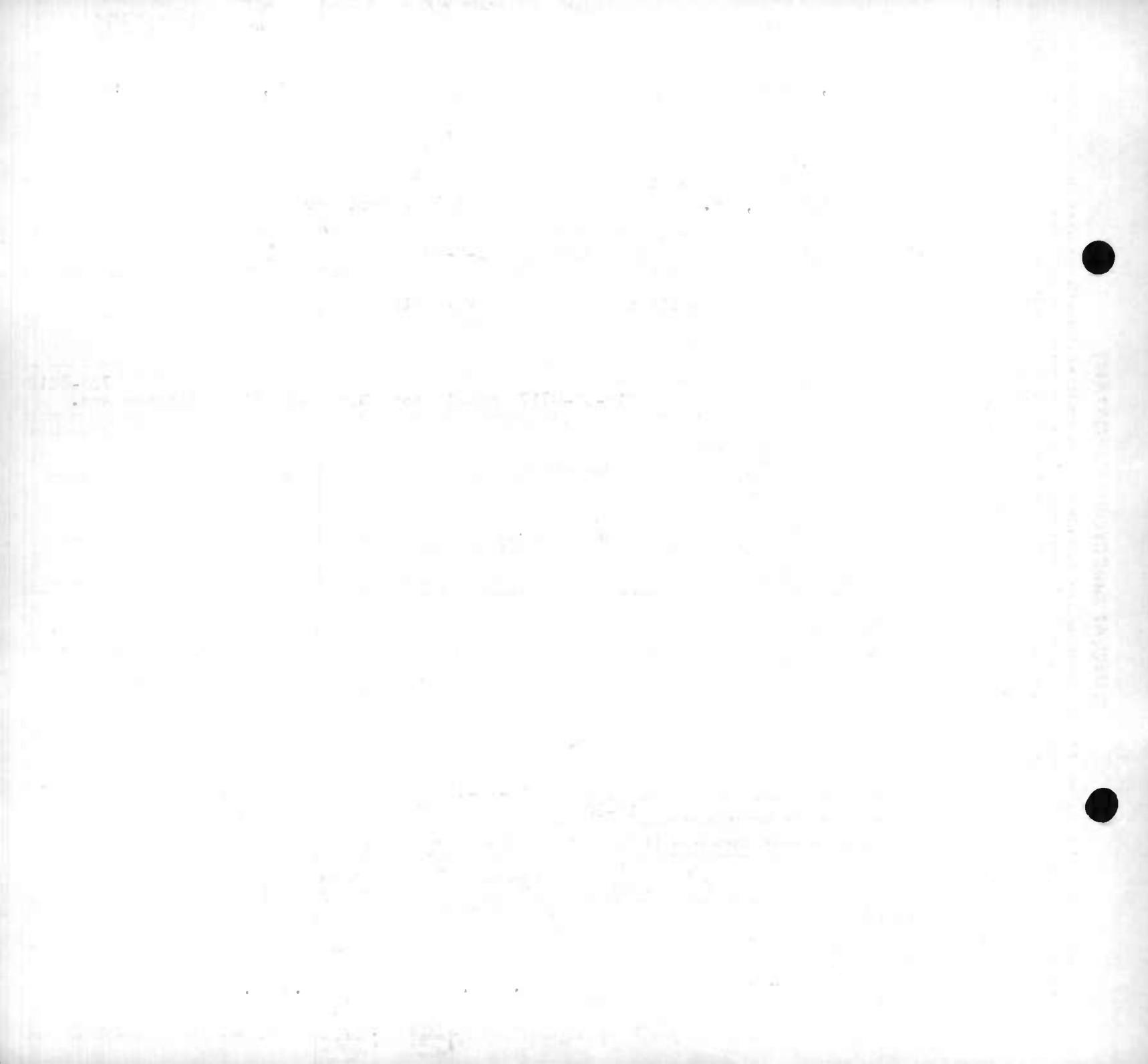
K-460 71 12250		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12250	
BIRTH NO.		2. DATE AND HOUR OF DEATH 12-31-71 1 2 AM			
1. NAME OF DECEASED (Type or Print) <b>Rahier Ronald</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2610</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CHILDRENS HOSPITAL</b>		C. CITY OR TOWN <b>Baltimore</b> E. STREET AND NUMBER <b>248 S Highland A</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-23-47</b> 9. AGE (in years lost birthday) <b>23</b> If Under 1 Yr. Months: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ernest</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Celazzi</b>		17. INFORMANT ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. MEDICAL CERTIFICATION <b>None</b>		19B. DATE OF OPERATION <b>None</b>		19C. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>6-1-70</b> to <b>12-31-71</b> 19 <b>71</b> that <b>(I)</b> (we) last saw the deceased alive on <b>12-31-71</b> and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur C. Burdett, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-31-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Arthur C. Burdett, M.D.</b>		23D. ADDRESS <b>3825 Greenspring Avenue, 21211</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>2x 1/4/72</b>		24C. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Zaffey, M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>	
				ADDRESS <b>263 S. Conkling Street</b>	

*Amphibolite* *metavolcanic* *rocks*

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

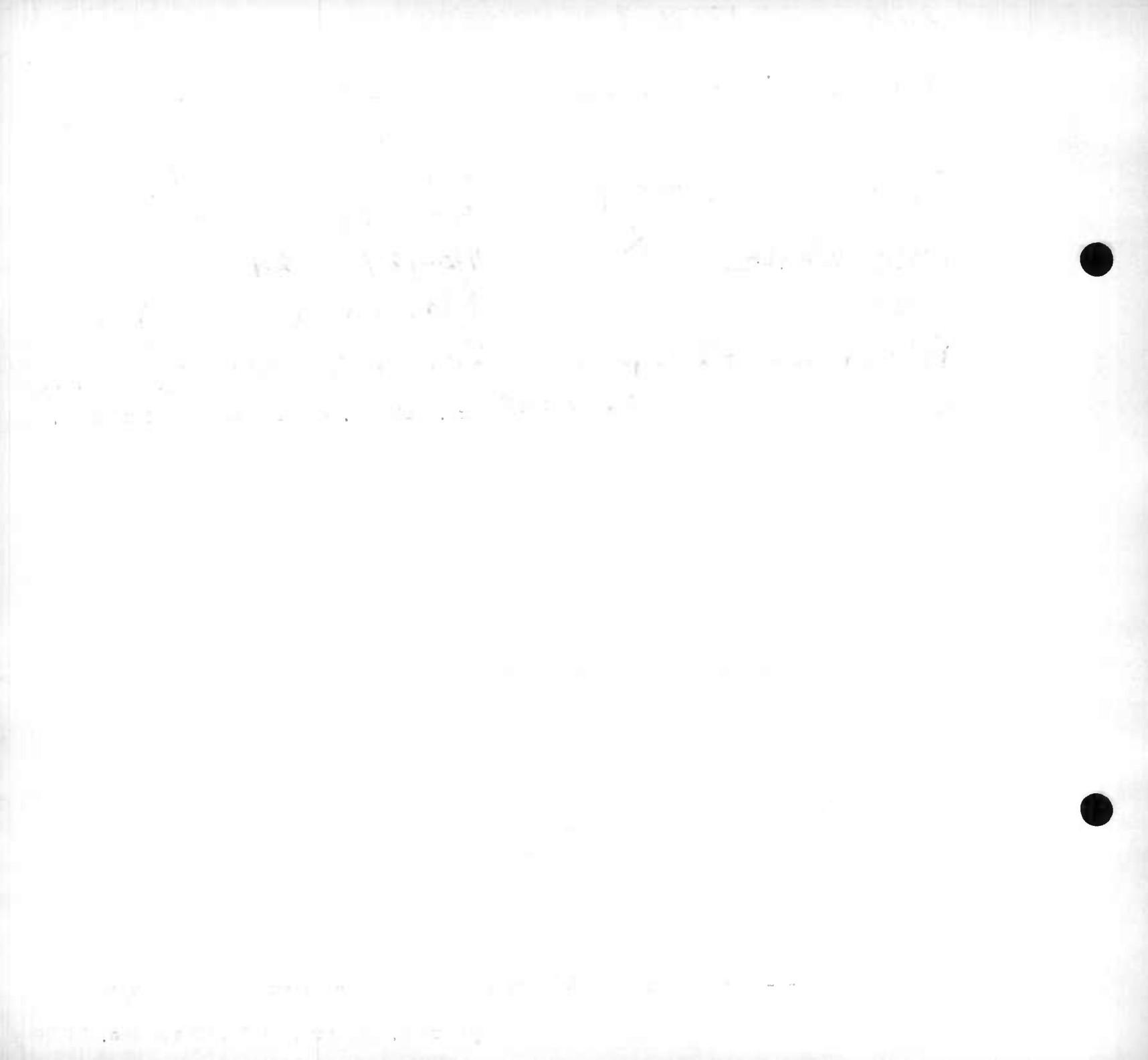
K-520		71 12251	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12251		
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		December 30, 1971   8:20 a.m.					
Knox, Roland							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD							
FULL NAME OF HOSPITAL OR INSTITUTION  39		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 1512					
(If not in hospital or institution, give street address or location) Provident Hospital 2600 Liberty Hospital Baltimore, Md.							
5. SEX Male 6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-04		9. AGE IN YEARS lost birthday 07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Knox		14. MOTHER'S MAIDEN NAME Maggie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-32-0717	
17. INFORMANT Mabel Knox (Daughter) 716 Arlington Ave.		18. CAUSE OF DEATH		ADDRESS 728-8212			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF: carcinoma of pancreas associated with congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) Aortic insufficiency?					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? In Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-18-71 to 12-30-71 that (I) (we) last saw the deceased alive on 12-30-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED 1/1/72					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. PHYSICIAN'S NAME (Type) F. Kogel, M.D. DEGREE			
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-4-72 24C. NAME OF CEMETERY OR CREMATOR Y Arbucus Mem. Pk. 24D. LOCATION Balto., Md. (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972 25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-412		71 12252		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12252	
BIRTH NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or print)		2. DATE AND HOUR OF DEATH Dec. 30, 1971 10 P.M.					
Mr. Isaac Phillipson		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  Bon Secours Hosp. 34					
FULL NAME OF HOSPITAL OR INSTITUTION		4. USUAL RESIDENCE (Where deceased lived if institution residence before admission) A. STATE Maryland B. COUNTY 2004 C. CITY OR TOWN Baltimore E. STREET AND NUMBER 332 Tyrone St.					
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/87 9. AGE (in years lost birthday) 84 II Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Alexander Phillipson		14. MOTHER'S MAIDEN NAME Henrietta Herzog		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 216-18-0453	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT Mrs. Helen M. Phillipson, 332 Tyrone St.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <i>Cardio Pulmonary Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <i>Atherosclerotic cardiovascular disease.</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) <i>Rt.-lower lobe Pneumonia.</i>					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19/30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arvanee Bichairo Narongsongram</i>		H.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/30/71			
23C. PHYSICIAN'S NAME (Type) ARVANE BICHAIRO NARONGSONGRAM		23D. ADDRESS Bon Secours HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-1972		24C. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery,		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR John H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



71 12253 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

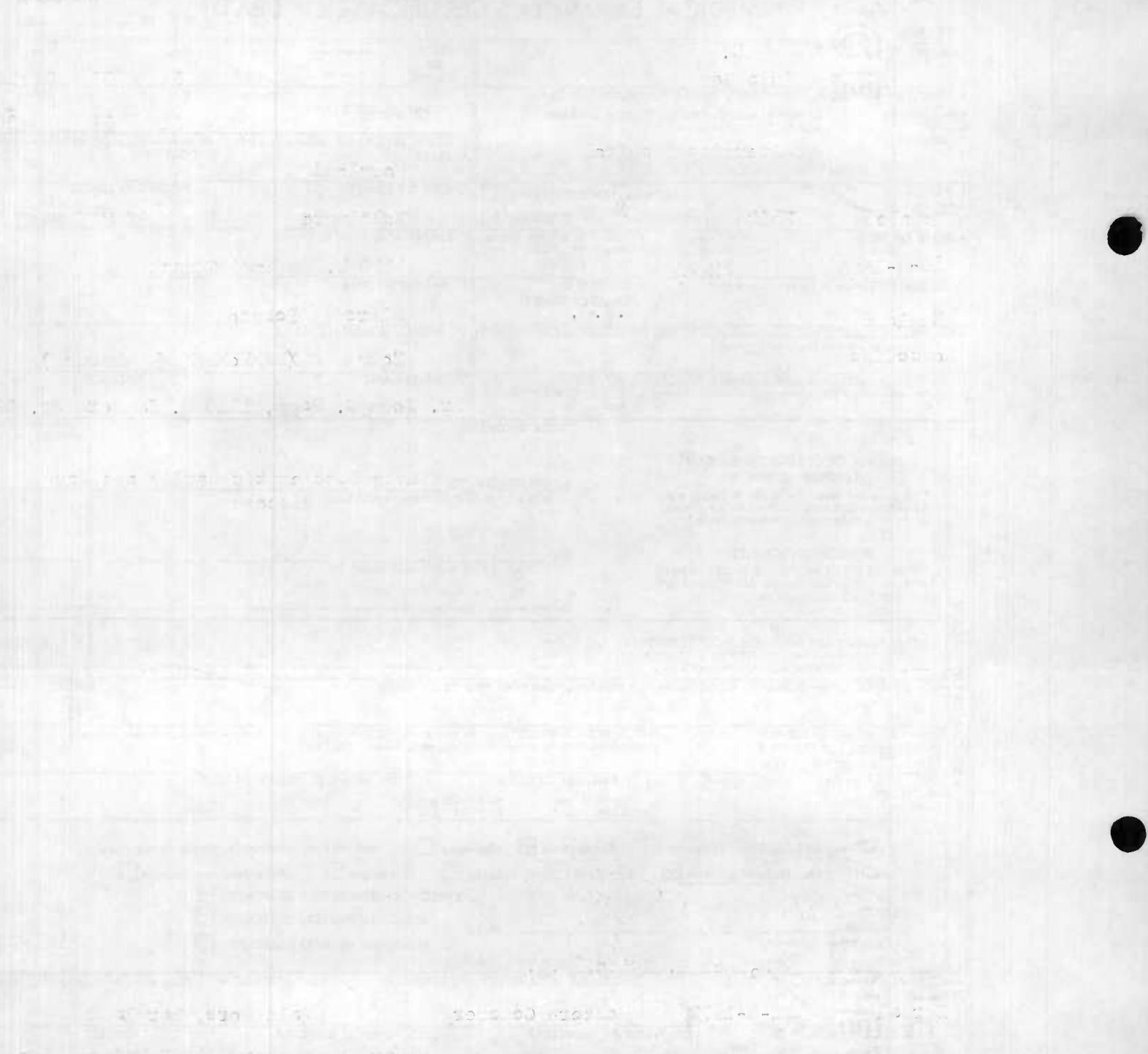
71 12253

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		E. Lula Rapp		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 31	Year 71	Hour 10:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	Estimated <input type="checkbox"/>	Month 12	Day 31	Year 71	Hour 10:20 P.M.
38 University Hospital				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
6. SEX Female		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 10-4-1886		10. AGE (In years last birthday) 86 85	11. Months Days Hours Min.	E. STREET AND NUMBER 1110 W. Lombard Street					
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Alfred Peaston					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Tody <input checked="" type="checkbox"/> (Unknown)					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Mr. John G. Rapp, 1110 W. Lombard St. 21223 ADDRESS					
19. 412.4 I		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-1972	24C. NAME of CEMETERY or CREMATORIAL Western Cemetery	24D. LOCATION (City, town, or county) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert L. Spitz, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS					

881.15

881.15



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452		71 12254	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. X 71 12254
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12/31/71 13 A M			
Collins, HARRY L.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
42 SINAI HOSPITAL OF BALTIMORE				A. STATE MD. B. COUNTY BALTO 5300	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
				8. DATE OF BIRTH 5/24/07 9. AGE (in years lost birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Comptroller Balt. Country Club		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Collins				14. MOTHER'S MAIDEN NAME Alberta Shillings	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-8094		17. INFORMANT Mrs. Violet M. Collins	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				ADDRESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 h	
				(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF:	
				(B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:	
				(C) A.S.C.U.D	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
19C. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (we) attended the deceased from that (I) (we) last saw the deceased alive on 12/31 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/31/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Leonardo E. Vinzera		SINAI Hospital of Balt.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 1/3/72		24C. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Mas.	
				24D. LOCATION (City, town or county) Balt.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. 21212	
				ADDRESS	



71 12255

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12255

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN TRUITT

2. DATE Known  Month Dec 29, 1971 Year 1971 Hour 10:35 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
58

University Hospital

3. DATE Estimated  Month Dec 29, 1971 Year 1971 Hour(If not in hospital or institution, give street  
address or location)

5. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE Maryland B. COUNTY BALTIMORE

6. SEX Male 7. RACE White 8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES  NO 9. DATE OF BIRTH OCT. 2, 1948 10. AGE (In years last birthday) 23 If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER 7123 A Rolling Bend Road

11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GORDON E. TRUITT

14A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) TEACHER 14B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY

15. MOTHER'S MAIDEN NAME M. ANGELA STAPLETON

16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (Yes, no or unknown) (If yes, give war or dates of service) A.M. 1970 - Dec. 1970 17. SOCIAL SECURITY NO. 213-52-1964

18. INFORMANT Joan F. Truitt - 7123 A Rolling Bend Rd. ADDRESS

19. E8180 I CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Multiple injuries

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
Yes

11-30-71 Head injuries

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Highway

Roland Road and Rte. #40

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 11-30-71 12:15 A.m.22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE AT WORK 

22F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

23. I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE Charles S. Springate  
EXAMINER'S  
NAME (Type) M.D.CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER  DATE SIGNED  
December 30, 197124A. BURIAL CREMATION,  
REMOVAL (Specify) Burial 24B. DATE 1-3-72 24C. NAME OF CEMETERY or CREMATORIAL  
Takoma Cemetery24D. LOCATION (City, town, or county) (State)  
Carroll County, Md.25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972 25B. NAME OF REGISTRAR  
197100025C. FUNERAL DIRECTOR  
Foley Company Wm. Catonville, Md.  
ADDRESS

1-27-72 - Letter - Completion of cause of Death on a Pending Medical Examiner Death  
Certificate - Charles S. Springate, M.D.

HRS

71 12256

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12256

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Florence C. Frampton

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

415 S. Bentalous Street

6. SEX

Female

7. RACE

White

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. DATE OF BIRTH

NOV. 7-1916

54

10. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

RICHMOND VIRGINIA

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

WHITE S.S.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

17. SOCIAL SECURITY NO.

225-12-1014

18. INFORMANT

OTTIS FRAMPTON - 415 S. BENTALOUS ST

19. CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,

heart failure, asthma, etc. It means the disease,

injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE TERMINAL

DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS

UNDERLYING  OR CONTRIB-UTING  CAUSE OF DEATH.

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY (APPROX.)

12 26 71 8:37 P.M.

22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

Street

22E. INJURY OCCURRED

WHILE AT WORK NOT WHILE AT WORK 22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Ostend and Sharp Streets

22F. HOW DID INJURY OCCUR?

Auto accident

23.

I certify that I held on Inquiry Inspection Autopsy 

and that on this basis, death in my opinion

resulted from: Natural causes Accident Suicide Homicide Undetermined manner Deputy CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

1-1-72

ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

24A. BURIAL OR CREMATION  
REMOVAL (Specify)

1/3/72

24B. DATE

LONDON PARK CEM

24C. NAME OF CEMETERY or CREMATORI

Y

24D. LOCATION (City, town, or county) (State)

FREDERICK AVE. MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1972

25B. NAME OF REGISTRAR

KRAVETZ

25C. FUNERAL DIRECTOR

KRAVETZ

ADDRESS

KRAVETZ FUN HOME 1216 S. CHARLES ST

VS 151-REV. 1/1/68

N 86810



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

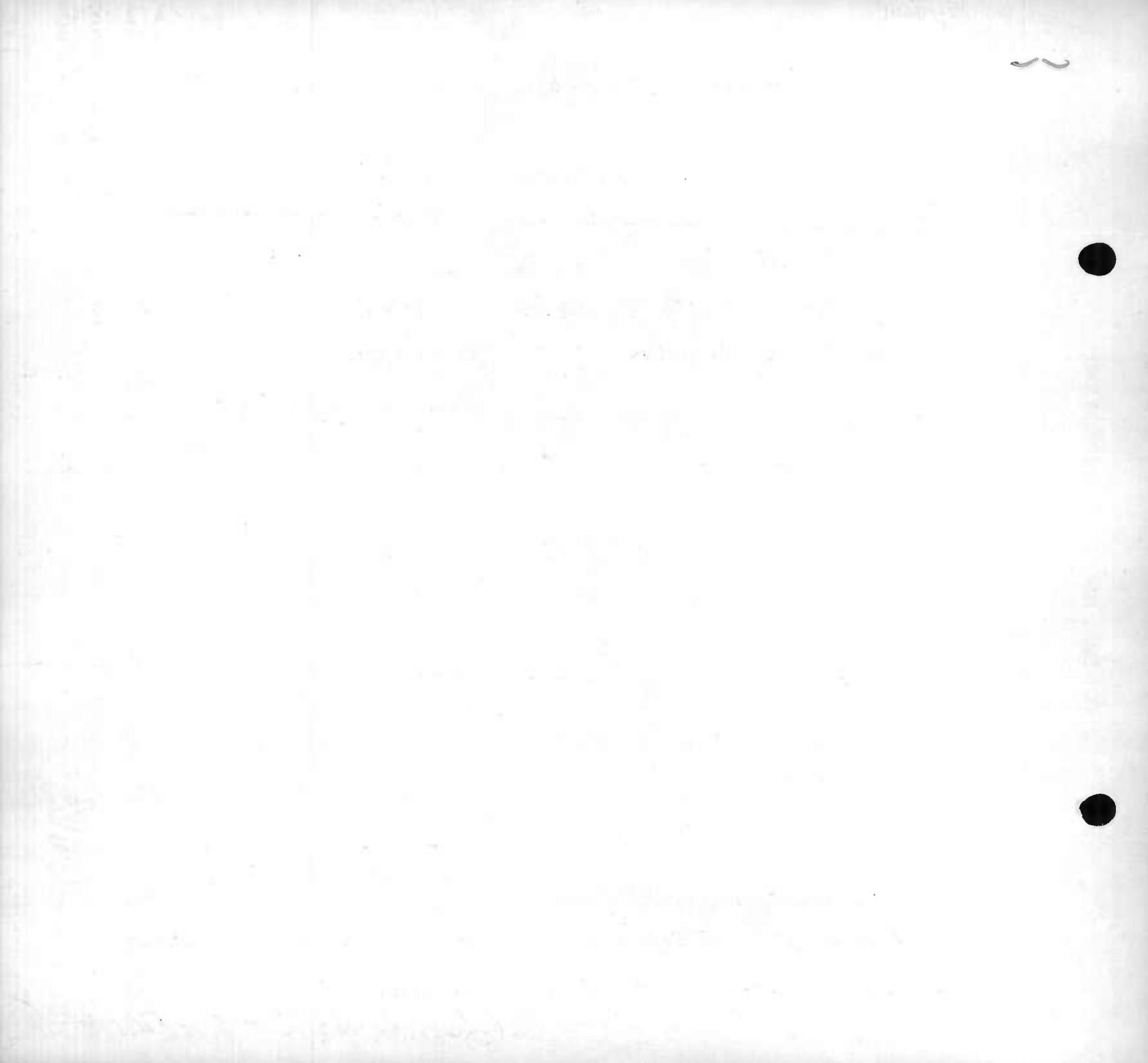
H-145		71 12257	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12257
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12-31, 1971 10 10 M.		
Margaret T. Haviland				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90</i>		A. STATE Md. B. COUNTY Baltimore		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Gould Convalesarium 6116 Belair Rd.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		E. STREET AND NUMBER 437 Evesham Ave		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		
13. FATHER'S NAME Patrick McGinity		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		14. MOTHER'S MAIDEN NAME Briget Dunnion		
16. SOCIAL SECURITY NO. 214 12 1195		17. INFORMANT Mr. Edward J. Haviland 515 W. Joppa Rd.		
18. I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Arteriosclerotic Heart Disease</i> -  <i>Generalized Arteriosclerosis</i>  <i>Chronic Congestive Heart Disease</i> <i>Chronic Brain Syndrome</i> <i>Osteoarthritis</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21D. TIME OF INJURY (APPROX.) 1 Monthl 1 Day 1 Year 1 Hour		21C. WHERE DID INJURY OCCUR? 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>we</del> ) attended the deceased from <i>11/5/1971</i> to <i>12/31/1971</i> , and that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/31/1971</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>not</del> ) (did not) view the body after death.				
23A. SIGNATURE <i>Albert B. Bradley</i>		23B. DATE SIGNED <i>1/3/72</i>		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.		23D. ADDRESS 4900 Belair Road 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery
24D. LOCATION Reisterstown		(City, town, or county) Balto		(State) Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. <i>[Signature]</i>		25C. FUNERAL DIRECTOR Mitchell <i>[Signature]</i>
				ADDRESS Wiedefeld Home 6500 York Rd.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12258		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12258	
1. NAME OF DECEASED (Type or Print)		Abraham Kahn		2. DATE AND HOUR OF DEATH		December 31/71 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland	B. COUNTY BALTO	C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
90 Edgewood Nursing Home Bellevue & Belvedere Ave				E. STREET AND NUMBER 6652 Sango Road apt C					
5. SEX Male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday) 84		If Under 1 Yr. Months Days Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Abraham Kahn		14. MOTHER'S MAIDEN NAME Sarah?		15. INFORMANT		16. SOCIAL SECURITY NO. ADDRESS apt C			
17. WAS Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		18. CAUSE OF DEATH		CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  art and CVA + CNS							
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)							
II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. MEDICAL CERTIFICATION DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		12/31 1971		12/31 1971					
23A. SIGNATURE Maurice Feldman MD		DEGREE		Attending Phys. <input checked="" type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 1/1/72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6610 Cross County Blvd							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Jan 27/72		24C. NAME OF CEMETERY or CREMATORIAL		24D. LOCATION (City, town, or county) Baltimore, MD		(State)	
Burial		Jan 27/72		Buck Isaac Adath Jeshua		Baltimore, MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972		25B. NAME OF REGISTRAR Robert E. Bailey, MD		25C. FUNERAL DIRECTOR Sol Lazarus, Esq.		ADDRESS 6610 Cross County Blvd - Baltimore, MD			
VS 150-REV. 1/1/68									



## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12259

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH LYONS

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

6. SEX

Male

7. RACE

White

8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

9. DATE OF BIRTH

NOVEMBER 4, 1927

10. AGE (in years last birthday)

44XX

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MERCHANT

14B. KIND OF BUSINESS OR INDUSTRY

RETAIL

15. MOTHER'S MAIDEN NAME

MAURICE LYONS

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREAN WAR

17. SOCIAL SECURITY NO.

216-20-7138

18. INFORMANT

FANNIE HELLER

ADDRESS

MRS. SELMA LYONS, 6804 WELLWOOD CT. #21209

## MEDICAL CERTIFICATION

E 965 IX

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Gunshot wound of abdomen

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about

home, farm, factory, street, office bldg., etc.)

American Meat Market

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

1703 Guilford Avenue

22D. TIME (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT

NOT WHILE

AT WORK

(APPROX.)

12-30-71

5:25 P.

m.

22F. HOW DID INJURY OCCUR?

Shot during attempted robbery and assault

23.

I certify that I held on Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE

Ronald N. Kornblum, M.D.

M.D.

EXAMINER'S  
NAME (Type)CHIEF MEDICAL EXAMINER 

DATE SIGNED

ASSISTANT MEDICAL EXAMINER 

12/31/71

ASSOCIATE MEDICAL EXAMINER 24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

1-2-1972

24C. NAME of CEMETERY or CREMATORIUM

LIBERTY PARK

24D. LOCATION (City, town, or county) (State)

RANDALLSTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1972

25B. NAME OF REGISTRAR

Robert E. Tauber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  
BALTIMORE, MARYLAND 21215



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-260		71 12260	BALTIMORE CITY HEALTH DEPARTMENT	CERTIFICATE OF DEATH	X REG. NO. 71 12260
BIRTH NO.		2. DATE AND HOUR OF DEATH 12/31/71 8:25 PM			
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
LUCILLE MAZER		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND	B. COUNTY BALTO 5300
SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		9. AGE (In years lost birthday) 45	11. Under 1 Tr. Months 12. Under 1 Tr. Days If Under 24 Hrs. Hours Min.
13. FATHER'S NAME Nathan Mutterman		14. MOTHER'S MAIDEN NAME Sarah		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Bernard Mazer - Same	
18. CAUSE OF DEATH SUBARACHNOID HEMORRHAGE					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: POSTERIOR COMMUNICATING ARTERY ANEURYSM					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 12/30/71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL ANEURYSM	20A. AUTOPST? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31/71 to 12/31/71 that (I) (we) last saw the deceased alive on 12/31/71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert Mennu M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/31/71	
23C. PHYSICIAN'S NAME (Type) ISRAEL WEINER, M.D.		23D. ADDRESS Sinai Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/72		24C. NAME OF CEMETERY OR CREMATORIUM Chet Shalom	24D. LOCATION (City, town, or county) Balto, Md. (Westchester)
25A. DATE REC'D BY HEALTH DEPT. Jan 5 1972		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.		25C. FUNERAL DIRECTOR Robert E. Fahey, M.D.	
VS 150-REV. 1/1/68					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1. NAME OF DECEASED (Type or Print)		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12261
<i>C-145</i> 71 12261 GILBERT CAPLAN		2. DATE AND HOUR OF DEATH 12-31-71		7:10 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 6964 GLENHEIGHTS RD. #15		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 2831
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-26-1903	9. AGE (in years lost birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT	10B. KIND OF BUSINESS OR INDUSTRY INSURANCE	11. BIRTHPLACE (State or foreign country) LIVERPOOL, ENGLAND	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HYMAN CAPLAN		14. MOTHER'S MAIDEN NAME LEAH KELLY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. ROSE CAPLAN, 6964 GLENHEIGHTS RD. #21215	ADDRESS	
18. <i>4124</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF: CHF  (C) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		RENAL FAILURE		
19A. DATE OF OPERATION <i>O</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-03 1971</i> to <i>12-31 1971</i> that (I) (we) last saw the deceased alive on <i>12-31 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.				
23A. SIGNATURE <i>Peter Oroszlan</i>		HD DEGREE	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>12-31-71</i>
23C. PHYSICIAN'S NAME (Type) PETER OROSZLAN		23D. ADDRESS 3 HAMILL RD Apt 5.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-2-1972	24C. NAME of CEMETERY or CREMATORIAL MIKRO KODESH	24D. LOCATION BALTIMORE, MARYLAND	(City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1972	25B. NAME OF REGISTRAR <i>J. E. Nutter, M.D.</i>	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	ADDRESS	

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## **FUNERAL DIRECTOR: IMPORTANT**

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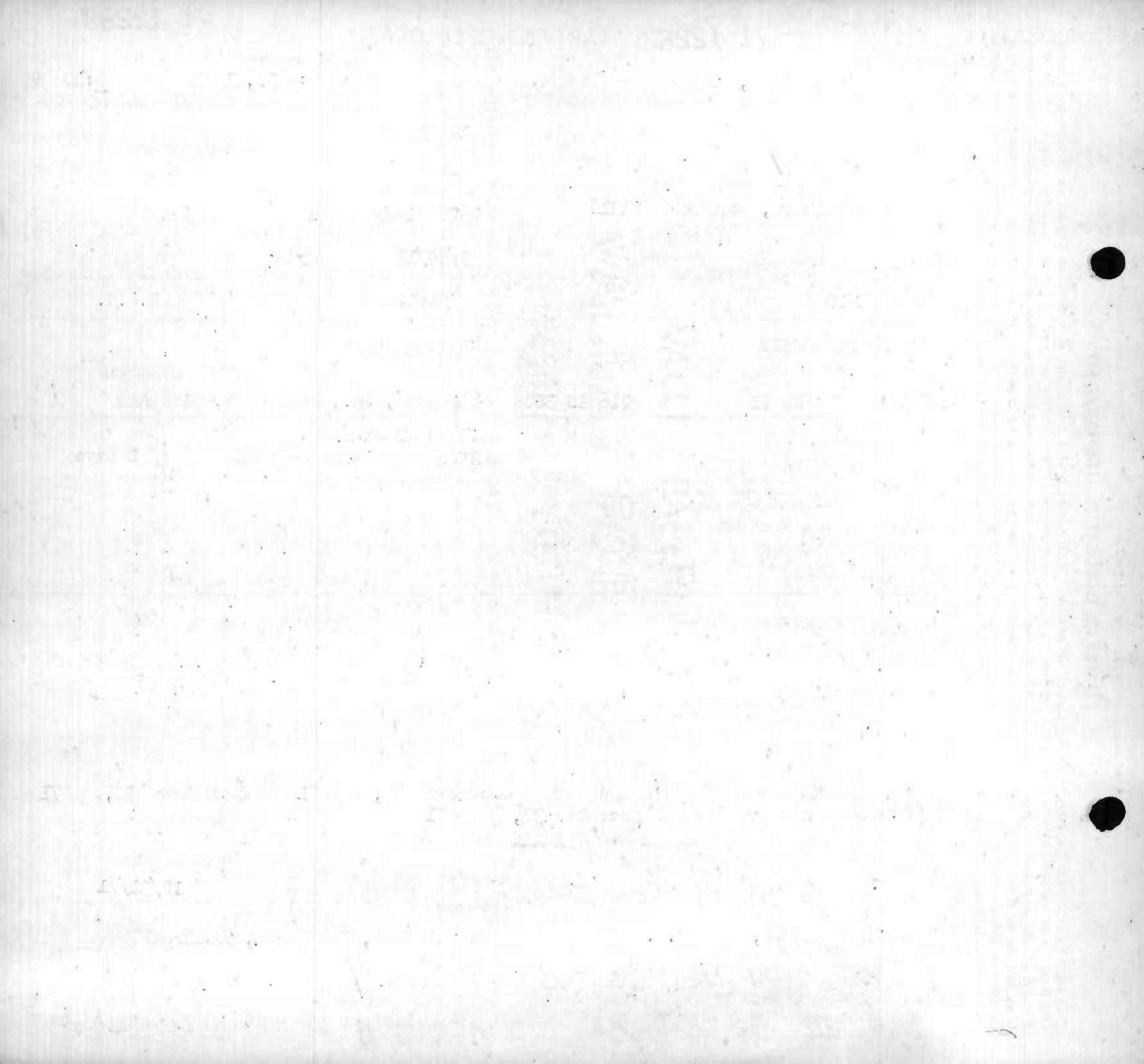
W-452		71 12262	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 71 12262
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		HUBERT WILLIAMS		2. DATE AND HOUR OF DEATH 12-31-71 2:00 PM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE & COUNTY MARYLAND A. A. CO 5200
THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE		6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-30-12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Plumber		9. AGE (in years last birthday) 59
13. FATHER'S NAME HUBERT WILLIAMS		11. BIRTHPLACE (State or foreign country) Cass West Va,		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 233 70 3477		12. CITIZEN OF WHAT COUNTRY? USA
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior Myocardial Infarxn		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypoxia		
		(C) CARCINOMA - METASTATIC TO LUNG		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (We) attended the deceased from December 29 1971 to December 31 1971 that (I) (we) last saw the deceased alive on December 31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.				
23A. SIGNATURE Ronald J. Innerfield, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Ronald J. Innerfield, M.D.		23D. ADDRESS 6004 East Pratt Street, Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/4/72	24C. NAME of CEMETERY or CREMATORIAL Glen Haven Cemetery	24D. LOCATION Glen Burnie Md.	(City, town, or county) (State)
25A. RATE REC'D BY HEALTH DEPT. JAN 5 1972	25B. NAME OF REGISTRAR Robert E. Johnson, Jr.	25C. FUNERAL DIRECTOR John D. Funeral Home 237	ADDRESS atapsco Ave 21225	

100% of the time

**FUNERAL DIRECTOR: IMPORTANT**

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S-625 BIRTH NO.		71 12263		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12263	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH December 30, 1971		6:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1605			
FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> 3900 Loch Raven Blvd Baltimore, Maryland 21218				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23				E. STREET AND NUMBER 2522 Riggs Avenue		21216	
5. SEX <b>MALE</b>		6. RACE <b>NEGROID</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/29/13	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 58		If Under 1 Yr. Months Days Hours Min.	
13. FATHER'S NAME <b>MOSSON SCRUGGINS</b>				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>218 10 3005</b>		17. INFORMANT CLIN RCDS, VAH, BALTIMORE, MARYLAND		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH CEREBRAL DAMAGE LIVER AND RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
MEDICAL CERTIFICATION  19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 28, 1971 to December 30, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 30, 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input type="checkbox"/> (not) view the body after death.							
23A. SIGNATURE  <i>Lawrence Mills Jr.</i>		23B. DATE SIGNED <b>12/31/71</b>					
23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE MILLS, M.D.</b>		23D. ADDRESS VA HOSPITAL, BALTIMORE, MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-4-72</b>		24C. NAME OF CEMETERY or CREMATORIUM <b>ARBUTUS MEM PARK</b>		24D. LOCATION (City, town, or county) (State) <b>ARBUTUS, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>E. O. Wilson</b>		ADDRESS <b>1000 BRANTLEY</b>	
VS ISO-REV. 1/1/68							



## FUNERAL DIRECTOR: IMPORTANT

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M-635		71 12264	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12264		
BIRTH NO.		CERTIFICATE OF DEATH		M.			
1. NAME OF DECEASED (Type or Print)		LOUIS EDGAR MARTINDALE		2. DATE AND HOUR OF DEATH December 31, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Maryland B. COUNTY 2582		
FULL NAME OF HOSPITAL OR INSTITUTION <i>40</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore E. STREET AND NUMBER 2808 Washington Blvd.		
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-1897 9. AGE (in years lost birthday) 74 II Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Martindale		14. MOTHER'S MAIDEN NAME Lena Weisman		ADDRESS 21228			
15. Was Decoosered Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W W I 212-46-9746		17. INFORMANT Mr. Marvin E. Martindale, 1206 Canberwell Rd.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleric, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Sudden death - massive myocardial infarction</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>A. S. Heart disease</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>(c)</i>		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(D)		(E)			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1970</i> to <i>12-31</i> <i>1971</i> , and that (I) (we) last saw the deceased alive on <i>12-31</i> <i>1971</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley Ankudas</i>		23B. DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. DATE SIGNED <i>1-3-72</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Stanley Ankudas		DEGREE 1101 Maiden Choice Lane, Balto., Md. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-4-1972		24C. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Burial		JAN 7 1972		Howard H. Hubbard, 4107 Wilkens Ave. 21229		Howard H. Hubbard, 4107 Wilkens Ave. 21229	
VS 150-REV. 1/1/68							

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71 12265

BALTIMORE CITY HEALTH DEPARTMENT

71 12265

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John B. Sheffield

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

2. DATE Known  Month Day Year Hour A.M.  
OF DEATH Estimated  12 31 71 4:14 P.M.3. DATE PRONOUNCED DEAD Month Day Year Hour  
12 31 71 4:14 P.M.

6. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE Maryland B. COUNTY Carroll

6. SEX

7. RACE

Male White

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

C. CITY OR TOWN

Sykesville YES  NO 

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

2-7-1932

39

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

E. STREET AND NUMBER

509A - Klee Mill Road

14A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

Food Fair Co.

13. FATHER'S NAME

John J. Sheffield

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

Clarice V. Merrell

ADDRESS

21223

Mrs. Joan Ann Sheffield, 1833 Frederick Ave.

19.

E 968 X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE Multiple traumatic injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

N

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (In Baltimore City, give exact location)  
INJURY OCCUR?

Found - Rear of 1700 E. 25th St.

22D. TIME (Month) (Day) (Year) (Hour)

12/31/71 A.M.

OF INJURY  
(APPROX.)

Unknown

22E. INJURY OCCURRED

WHILE AT WORK  NOT WHILE AT WORK m. 

22F. HOW DID INJURY OCCUR?

Unknown Run over by truck

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

NAME (Type)

Werner U Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

1-2-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-5-1972

24C. NAME of CEMETERY or CREMATORI

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 7 1972

25B. NAME OF REGISTRAR

Robert C. ...

25C. FUNERAL DIRECTOR

Howard H. Hubbard,

ADDRESS

21229

4107 Wilkens Ave.

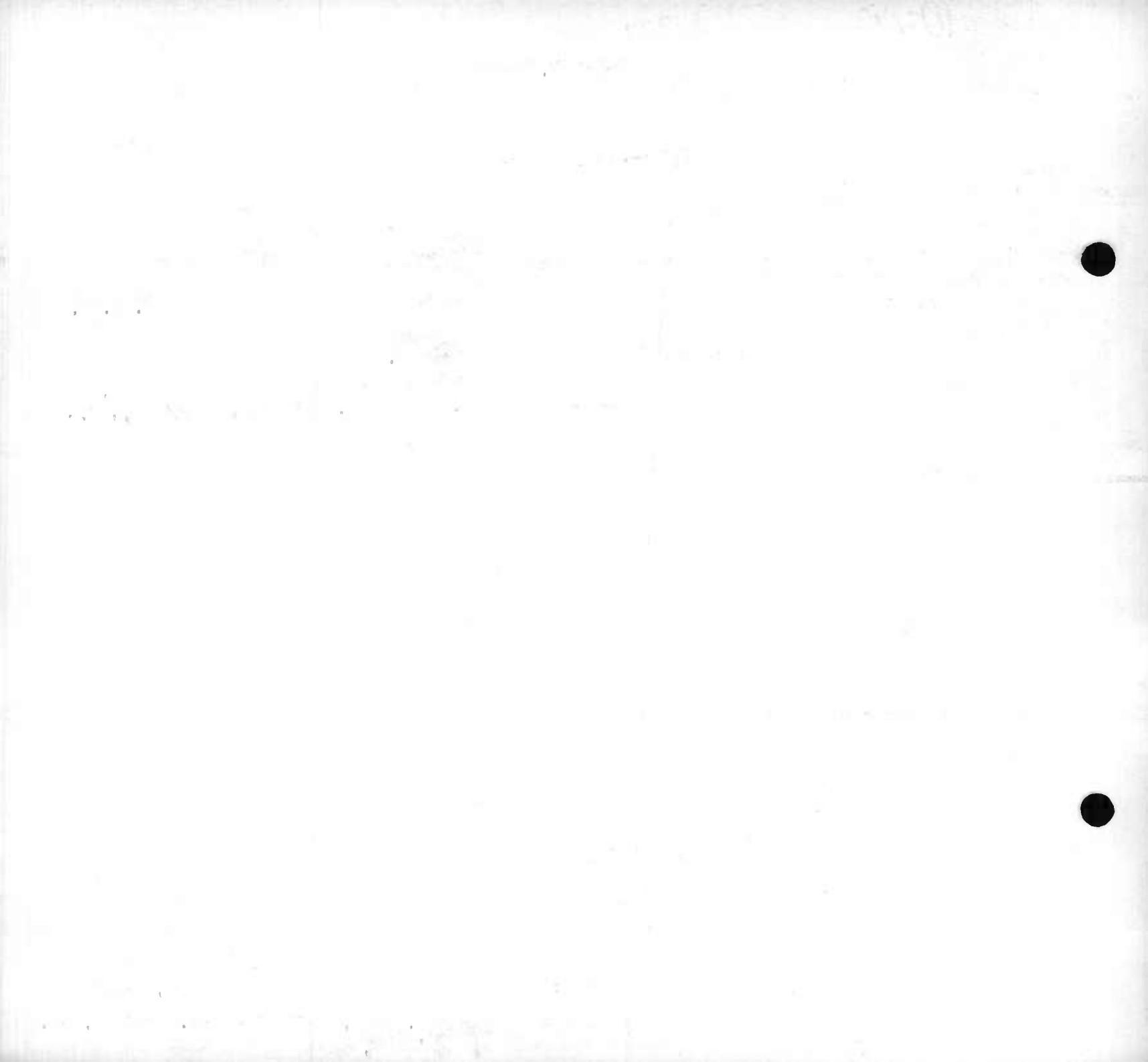
1-13-72 - Letter from - Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Assistant Medical Examiner

HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

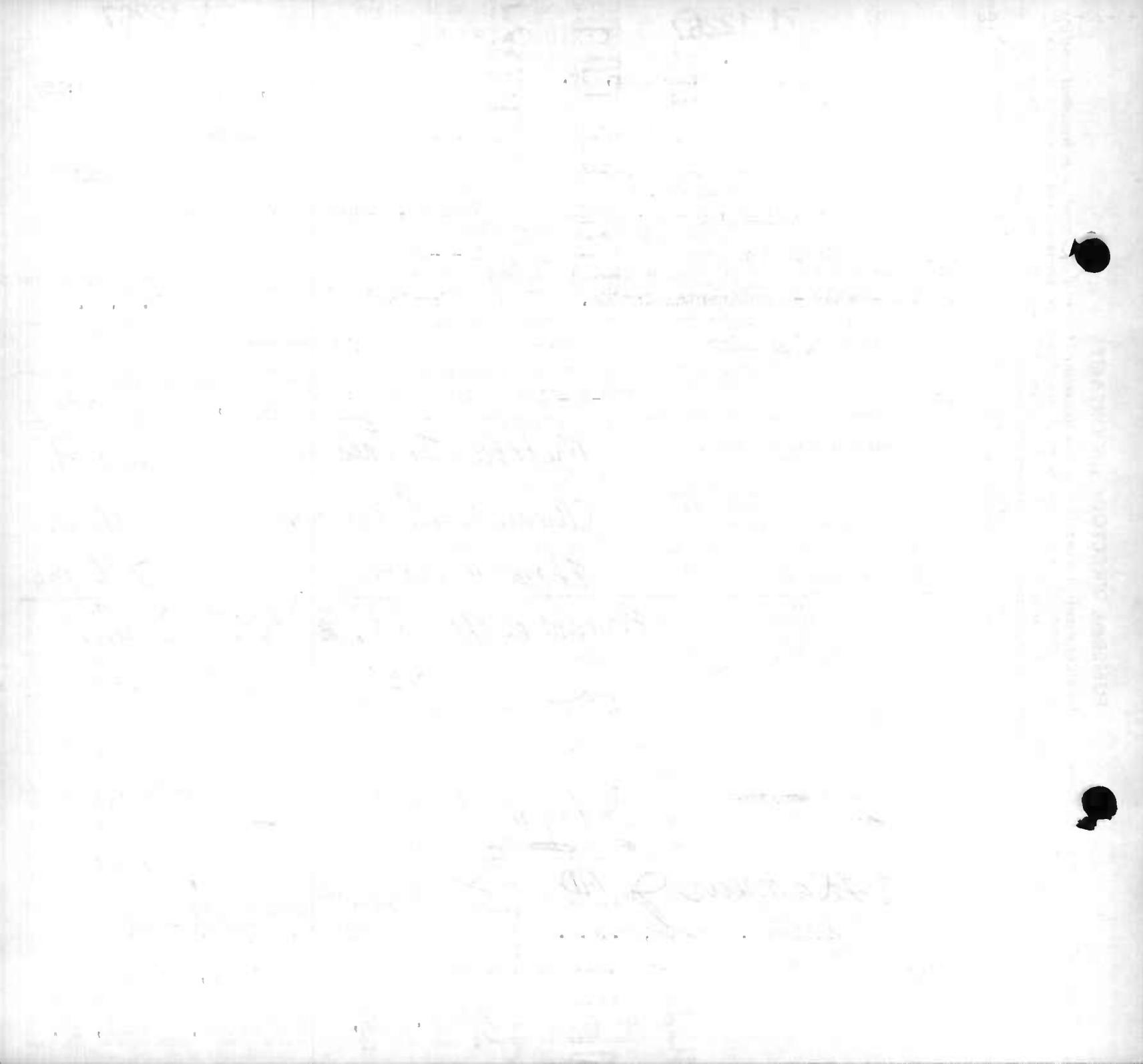
W-656		71 12266	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12266		
BIRTH NO.		CERTIFICATE OF DEATH		M.			
1. NAME OF DECEASED (Type or Print)		Sarah M. Warner		2. DATE AND HOUR OF DEATH 12/31/71 5:50 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Maryland B. COUNTY 302					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Johns Hopkins Hospital <i>Johns Hopkins Hosp.</i>		E. STREET AND NUMBER 909 E. Fayette Street					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/90	9. AGE (in years last birthday) 81	II Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Edward Brownawelle		14. MOTHER'S MAIDEN NAME Mary E. Horne				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-5759T				17. INFORMANT (Daughter) 1217 Travers Way, Mrs. Frances L. Griffith, Baltimore, Md.	
18. <i>444a</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Shock</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypovolemia + Heart Failure</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Possible SMA intact</i>					
20. MEDICAL CERTIFICATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <i>Atmospheric</i>		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/30/71</i> to <i>12/31/71</i> 19 and that (I) (we) last saw the deceased alive on <i>12/31/71</i> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John J. Duda MD</i>		23B. DATE SIGNED <i>12/31/71</i>					
23C. PHYSICIAN'S NAME (Type) <i>George J. Taylor MD</i>		23D. ADDRESS <i>Johns Hopkins Hosp. Baltimore Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY or CREMATORIAL Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1972</i>		25B. NAME OF REGISTRAR <i>John J. Duda</i>		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS <i>12611</i>	
VS 150-REV. 1/1/68							



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12267	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO.	71 12267
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH			
Francis Reinsfelder, Sr.		2. DATE AND HOUR OF DEATH			
		December 31, 1971 1:15p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland Baltimore B. COUNTY 5300			
FULL NAME OF HOSPITAL OR INSTITUTION  31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lift Operator - Continental Can Co.		10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.		8. DATE OF BIRTH 10-8-26 9. AGE (In years lost birthday) 45 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.	
13. FATHER'S NAME John Reinsfelder		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-8143		14. MOTHER'S MAIDEN NAME Elsie Connors	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Metabolic Imbalance APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~1wh.			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Chronic Renal Failure		10 mo.			
(B) DUE TO, OR AS A CONSEQUENCE OF:  Hypertension		710 mo.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Pericardial Effusion, Chronic Hypertension x ~1wh. hemiparesis			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROXIMATE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( ) attended the deceased from _____ to _____ that (I) ( ) last saw the deceased alive on 12/31/71 19_____ and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) ( ) (did) (not) view the body after death.		12/31/71 19_____ to 12/31/71 19_____			
23A. SIGNATURE  William L. Ramseur, Jr., M.D.		23B. DATE SIGNED 12/31/71			
23C. PHYSICIAN'S NAME (Type) William L. Ramseur, Jr., M.D.		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72		24C. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland		24E. CITY, TOWN, OR COUNTY BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Salter, Jr.		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.	
ADDRESS					
VS 150-REV. 1/1/68					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-416		71 12268	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH	REG. NO. 71 12268
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 12-30-71 19:58 P.M.		
MILBOURNE RONALD J.				
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		A. STATE Md. B. COUNTY Somerset 6900		
(If Not in Hospital or Institution, Give Street Address or Location) <i>33</i>		C. CITY OR TOWN CRISFIELD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 227 MAIN ST.				
5. SEX Male	6. RACE Caucasion	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1906	9. AGE (in years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Worker - Labr		10B. KIND OF BUSINESS OR INDUSTRY Fishing.		11. BIRTHPLACE (State or foreign country) Crisfield, Md.
13. FATHER'S NAME Romeo Milbourne		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		14. MOTHER'S MAIDEN NAME Grace M. Brown ? Hudson Name.		
16. SOCIAL SECURITY NO. 213-10-8039		17. INFORMANT Mrs. Ruby Milbourne, Same as 4. abcde		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ASCITES DUE TO, OR AS A CONSEQUENCE OF: Few weeks. (B) LIVER DISEASE DUE TO, OR AS A CONSEQUENCE OF: Unknown (C) Unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 12-27- to 1971 to 12-30-1971 that <input type="checkbox"/> (we) last saw the deceased alive on 12-30-1971 and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We) (did) <input type="checkbox"/> view the body after death.				
23A. SIGNATURE <i>Kenneth A. Krackow, MD</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-30-71
23C. PHYSICIAN'S NAME (Type) KENNETH A. KRACKOW		23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery
24D. LOCATION (City, town, or county) Crisfield, Somerset, Md.		(State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR R. E. Vining, Jr.		25C. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md. 21817
ADDRESS				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12269

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)JOHNNY  
JOHNNIE L. WHITE2. DATE Known  Month Day Year Hour  
OF DEATH Estimated 

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

641 N. Carey St.

3. DATE Month Day Year Hour  
PRONOUNCED DEAD 12 27 1971 10:10a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Md.

B. COUNTY 601

6. SEX male

7. RACE negro

8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS?  
YES  NO 

9. DATE OF BIRTH 12-30-1917

10. AGE (In years  
last birthday) 53II Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) High Point N.C.

12. CITIZEN OF U.S.A.

E. STREET AND NUMBER 641 N. Carey St.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Lucy Lawson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 7-14-456-10-18-453443-10-9031

18. INFORMANT Melvin Lukas

ADDRESS

19. CAUSE OF DEATH

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(A) IMMEDIATE CAUSE

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) WHILE AT WORK  NOT WHILE AT WORK 22E. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK   
22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)  
Russell S. Fisher, M.D.CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-27-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)  
Burial

24B. DATE 1-4-72

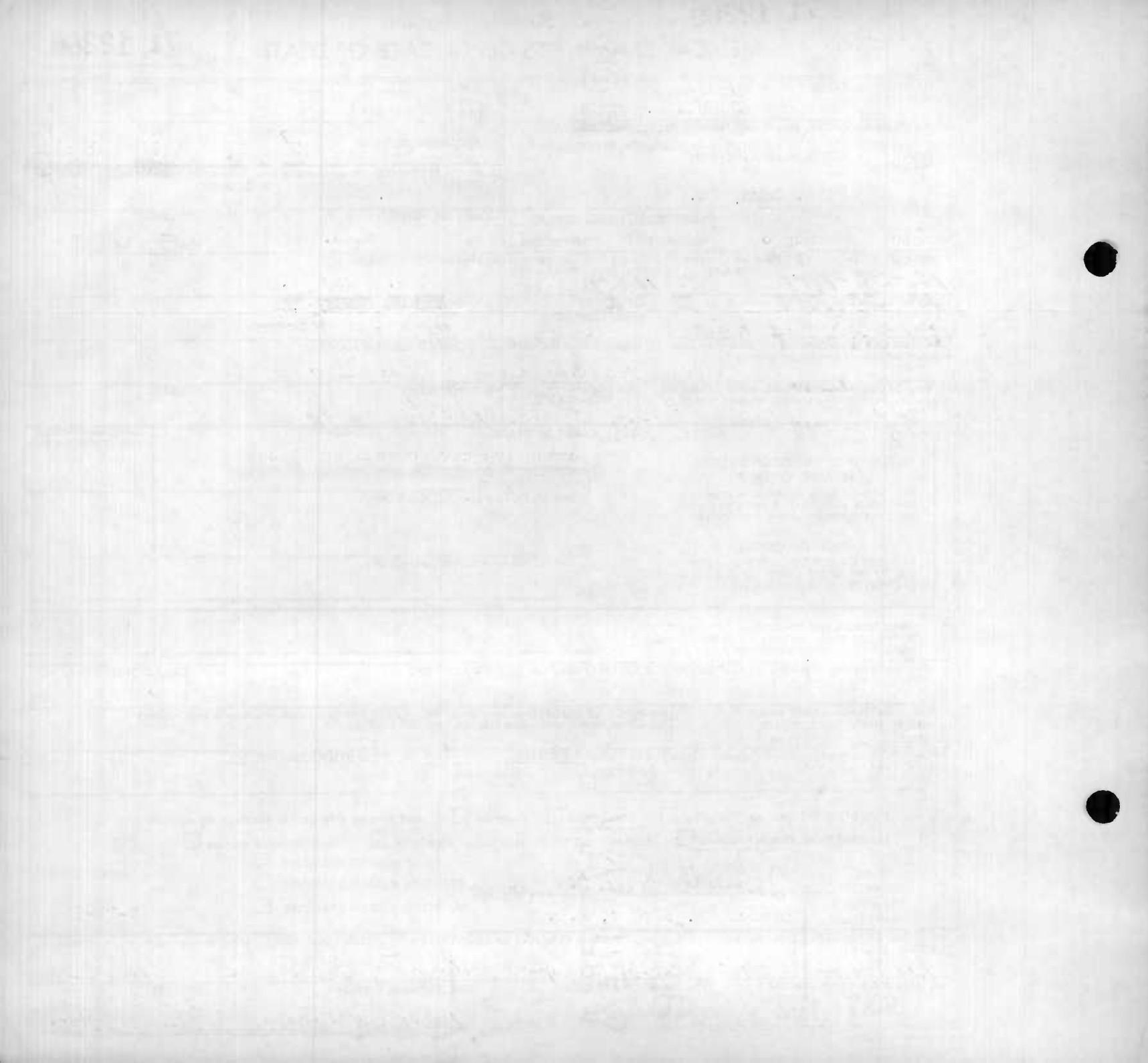
24C. NAME OF CEMETERY or CREMATORIAL  
Mt. Auburn Cemetery Baltimore24D. LOCATION (City, town, or county) (State)  
Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972

25B. NAME OF REGISTRAR Robert E. Jasby, M.D.

25C. FUNERAL DIRECTOR Bullock's Mortuary

ADDRESS 712-14 E. North Ave  
Baltimore, Md.



1 71 12270

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12270

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Kenneth C. Lancaster

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
31 Baltimore City Hospitals

6. SEX

Male

7. RACE

White

8. MARRIED

NEVER MARRIED WIDOWED DIVORCED 

9. DATE OF BIRTH

3/31/41

10. AGE (In years  
lost birthday)

30

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

14A. USUAL OCCUPATION (Give kind of work  
done during most working life, even if retired)

Plumber

(Yes, no or unknown) (If yes, give war or dates of service)

No

14B. KIND OF BUSINESS OR INDUSTRY

Plumbing

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

217 40 3797

18. INFORMANT

Marva Anne Lancaster (same)

ADDRESS

19. E8/20

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about

home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

Tunnel freeway - 150' N. of Poncabird Pass

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 12 31 71 4:17 P.m.

22E. INJURY OCCURRED

WHILE AT WORK 

NOT WHILE

AT WORK 

X

Driver of auto into bridge abutment

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinionresulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

1-2-72

24A. BURIAL CREMATION,  
REMOVAL  
(Specify)

Burial

24B. DATE

1/4/72

24C. NAME of CEMETERY or CREMATORIUM

Cedar Hill Cemetery

24D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A.A.C.O., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 7 1972

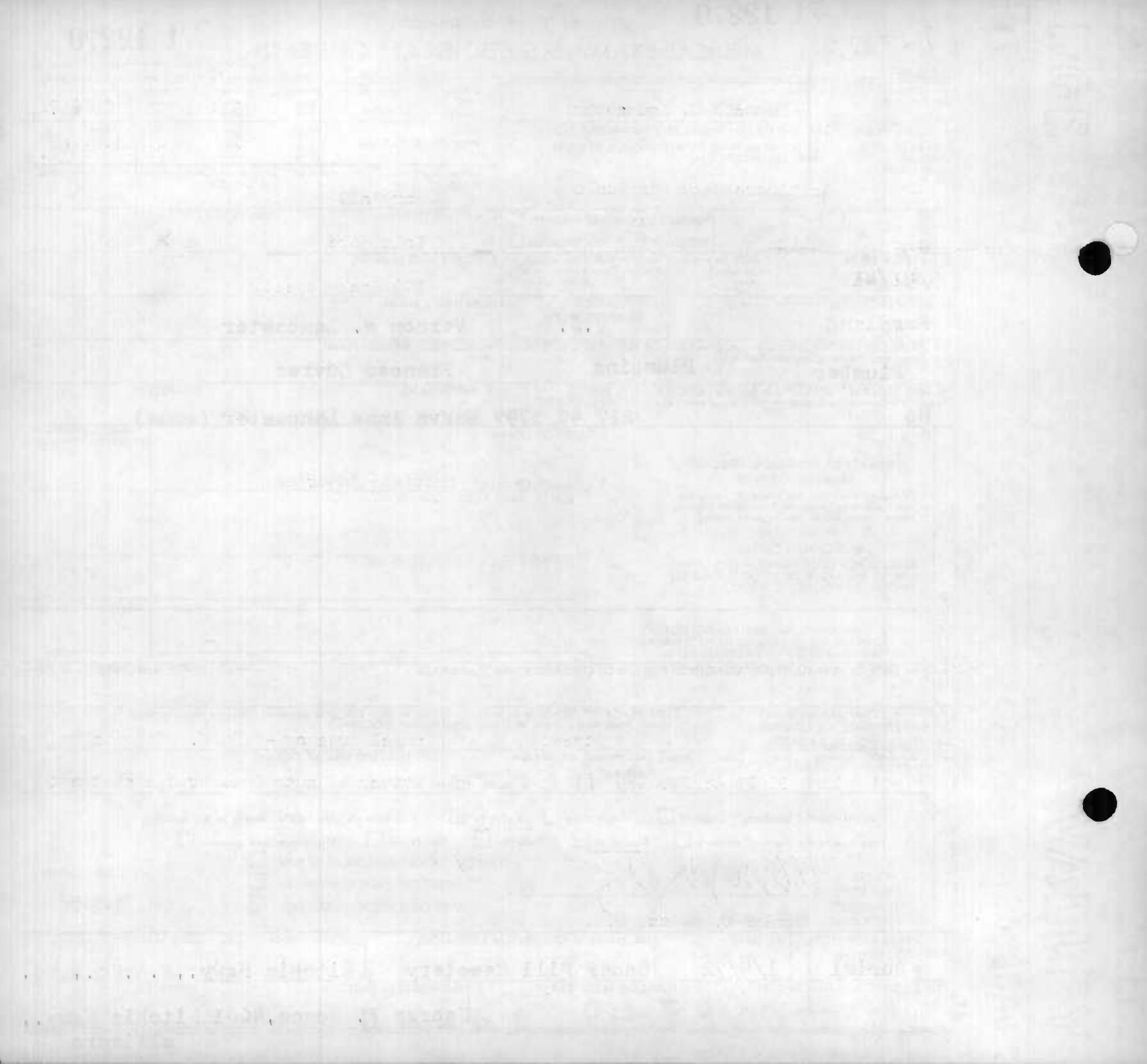
25B. NAME OF REGISTRAR

George J. Gonce, 4001 Ritchie Hwy.,

25C. FUNERAL DIRECTOR

ADDRESS

Baltimore



## **FUNERAL DIRECTOR: IMPORTANT**

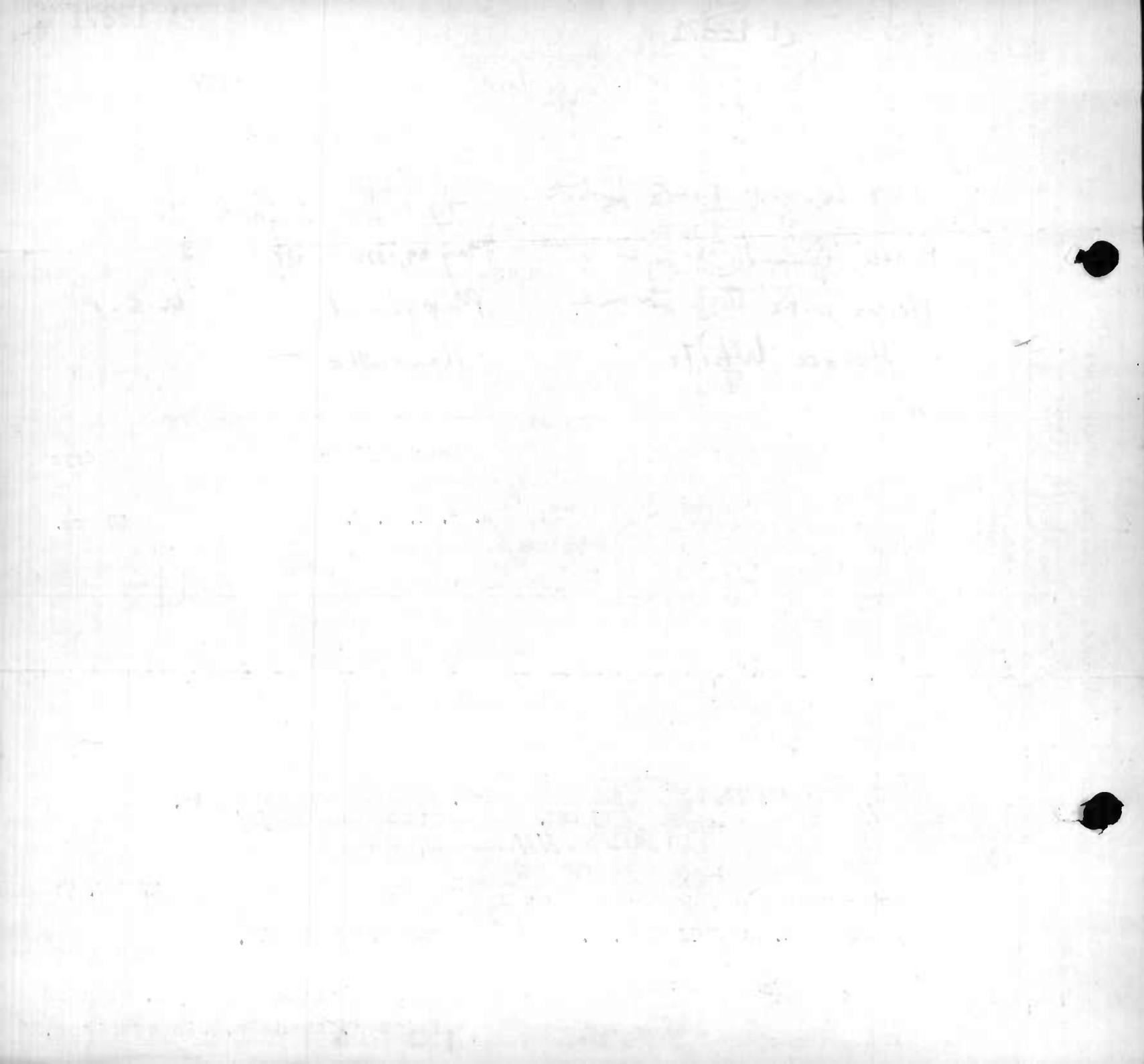
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Q-535 71 12271  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 11 16671

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Dec. 23, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. FULL NAME OF HOSPITAL OR INSTITUTION  FEMALE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland	
(If not in hospital or institution, give street address or location)  727 Druid Park Drive		B. COUNTY 1361	
5. SEX Female		C. CITY OR TOWN Baltimore	
6. RACE Colored		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 727 Druid Park Drive	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		B. DATE OF BIRTH May 29, 1880	
10B. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 91	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Horace White		14. MOTHER'S MAIDEN NAME Hannah ~	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES		CAUSE OF DEATH  Heart Failure	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  A. S. C. V. D.  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (In Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Feb. 1971 to Dec. 19 71 that (I) (we) last saw the deceased alive on 23 DEC. 19 71 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <input checked="" type="checkbox"/> view the body after death.			
23A. SIGNATURE  Joshua R. Mitchell III MD		23B. DATE SIGNED 27 DEC. 71	
23C. PHYSICIAN'S NAME (Type) JOSHUA R. MITCHELL III .MD.		23D. ADDRESS 2202 GARRISON BLVD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/70	
24C. NAME of CEMETERY or CREMATORIAL DEGREE		24D. LOCATION (City, town, or county) Venton Somerset, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Grace	
25C. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-200		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 57 71 312272
BIRTH NO.		CERTIFICATE OF DEATH		DR. APP'D DATE AND HOUR OF DEATH 31 Dec 1971 2:10 AM
1. NAME OF DECEASED (Type or Print)				DR. APPROVED DATE AND HOUR OF DEATH 31 Dec 1971 2:10 AM
Phillip N. Suggs				DR. APPROVED DATE AND HOUR OF DEATH 31 Dec 1971 2:10 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  UNIVERSITY OF MARYLAND		A. STATE MD.		Prince Georges 6600
(If not in hospital or institution, give street address or location)		B. COUNTY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		C. CITY OR TOWN Cheverly		D. INSIDE CITY LIMITS?
		E. STREET AND NUMBER P.O. Box 103 Boys Village		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-14	9. AGE (in years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Youth Supervisor Boys Village		11. BIRTHPLACE (State or foreign country) North Carolina
10C. FATHER'S NAME George Suggs		14. MOTHER'S MAIDEN NAME Sula		12. CITIZEN OF WHAT COUNTRY? USA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  <del>CHIEF MEDICAL EXAMINER'S CASE</del> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <del>ANTECEDENT CAUSES</del> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		CAUSE OF DEATH  <del>CHIEF MEDICAL EXAMINER'S CASE</del> MAIN IMMEDIATE CAUSE CHRONIC Renal Failure DUE TO, OR AS A CONSEQUENCE OF: Hypertension Hepatitis (B) DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis of Liver (C) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Infarction Quadraplegia (Cervical Spinal Lesion)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/29/71
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 7/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex of C3-C4		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) None		21C. WHERE DID INJURY OCCUR? None
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None
22. I certify that (I) (this hospital) attended the deceased from 11-10-71 19 to 12-31-71 19 that (I) (we) last saw the deceased alive on 12-31-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE George Koepdel M.D.		23B. DATE SIGNED 31 Dec 1971		
23C. PHYSICIAN'S NAME (Type) George Koepdel M.D.		23D. ADDRESS Univ of Maryland Hosp.		
24A. BURIAL OR CREMATION REMOVAL (Specify) 1-8-72 1-3-72		24B. DATE 24C. NAME of CEMETERY or CREMATORIUM Jenner		24D. LOCATION (City, town, or county) Baltimore, Md. (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR John E. Suggs		25C. FUNERAL DIRECTOR ADDRESS 389 Bt. see Mr. Wash. D.C.

Consequently the

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FUNERAL DIRECTOR: **IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-162

71 12273

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

71 12273

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JEFFERSON, William E.

2. DATE AND HOUR OF DEATH

12/31/71

4:00

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES NO 

E. STREET AND NUMBER

1224 E. North Avenue

5. SEX

Male

6. RACE

Negro

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

8. DATE OF BIRTH

5/16/12

9. AGE (in years  
last birthday)

59

If Under 1 Yr.  
Months

Days

Hours

Min.

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Floyd Jefferson

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

234-36-1201

17. INFORMANT

Margaret Jefferson 1224 E North

18. *430.91*

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE *Subarachnoid Hemorrhage*

DUE TO, OR AS A CONSEQUENCE OF:

4 days

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C):

*Hepatic Failure*

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work Not While  
At Work 22. I certify that (1) (this hospital) attended the deceased from 12/28 to 12/31  
that (1) (we) last saw the deceased alive on 12/31 19 71 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Richard L. Taw Jr MD*Attending  
Phys.  
DegreeMed.  
Director   
Staff  
Phys. 

23B. DATE SIGNED

12/31/7123C. PHYSICIAN'S  
NAME (Type)

Richard L. Taw,

M.D.  
Degree

The Johns Hopkins Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORIUM

24D. LOCATION

(City, town, or county)

(State)

Burial

1-10-72

Mt Auburn Cemetery

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 7 1972

Richard L. Taw Jr MD

Wh C- March 928 E. North Ave.

VS 150-REV. 1/1/68



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the physician by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-152 71 12274		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12274 4
BIRTH NO. 71-20645		2 DATE AND HOUR OF DEATH 10/11/71 9:00 am		
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Robinson A</i>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Baltimore Maryland</i> B. COUNTY <i>1512</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i> 42		5. SEX <i>female</i> 6. RACE <i>negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/10/71</i> 9. AGE (in years last birthday) <i>1</i> 10. KIND OF BUSINESS OR INDUSTRY <i>None</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Sinai Hospital</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>Ernest Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Robinson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
18. <i>769.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH <i>Hypertension D.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Prematurity</i>				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) _____				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>10/11/71 3:30 pm</i>
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Layne</i>		23B. DATE SIGNED <i>10/11/71</i>		
23C. PHYSICIAN'S NAME (Type) <i>Orbela Zarzuela</i>		23D. ADDRESS <i>Hospital of Baltimore</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>1-6-72</i>		24B. DATE <i>10/11/71</i>		24C. NAME of CEMETERY or CREMATORIUM 24D. LOCATION (City, Town or County) <i>Baltimore</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1972</i>		25B. NAME OF REGISTRAR <i>Rob. A.E. [Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE BCHR</i>



## FUNERAL DIRECTOR: IMPORTANT

VY 1601  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 12275

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

71 12275

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

THOMPKINS WEAVER, SR.

2. DATE AND HOUR OF DEATH

12/28/71

10:40

A M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)  
A. STATE \_\_\_\_\_  
B. COUNTY \_\_\_\_\_

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES NO 

E. STREET AND NUMBER

1937 E. LAFAYETTE AVE.

5. SEX

MALE

6. RACE

NEGRO

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chain Operator

10B. KIND OF BUSINESS OR INDUSTRY

Steel Co.

13. FATHER'S NAME

X JERRY WEAVER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-09-1591

17. INFORMANT

Tompkins Weaver Jr.

ADDRESS

510 Goodnow Rd., 21206

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY

LEADING TO DEATH

(This does not mean the mode of dying, e.g.,

heart failure, asthma, etc. It means the disease,

injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving

rise to the above cause (A) stating the

UNDERLYING CONDITION (last).

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE TERMINAL

DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

12/13/71

Ca. of Colon

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF

DEATH (Notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about

home, farm, factory, street, office bldg.,

etc.)

21C. WHERE DID

INJURY OCCUR?

12/13/71

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to 12/28/71

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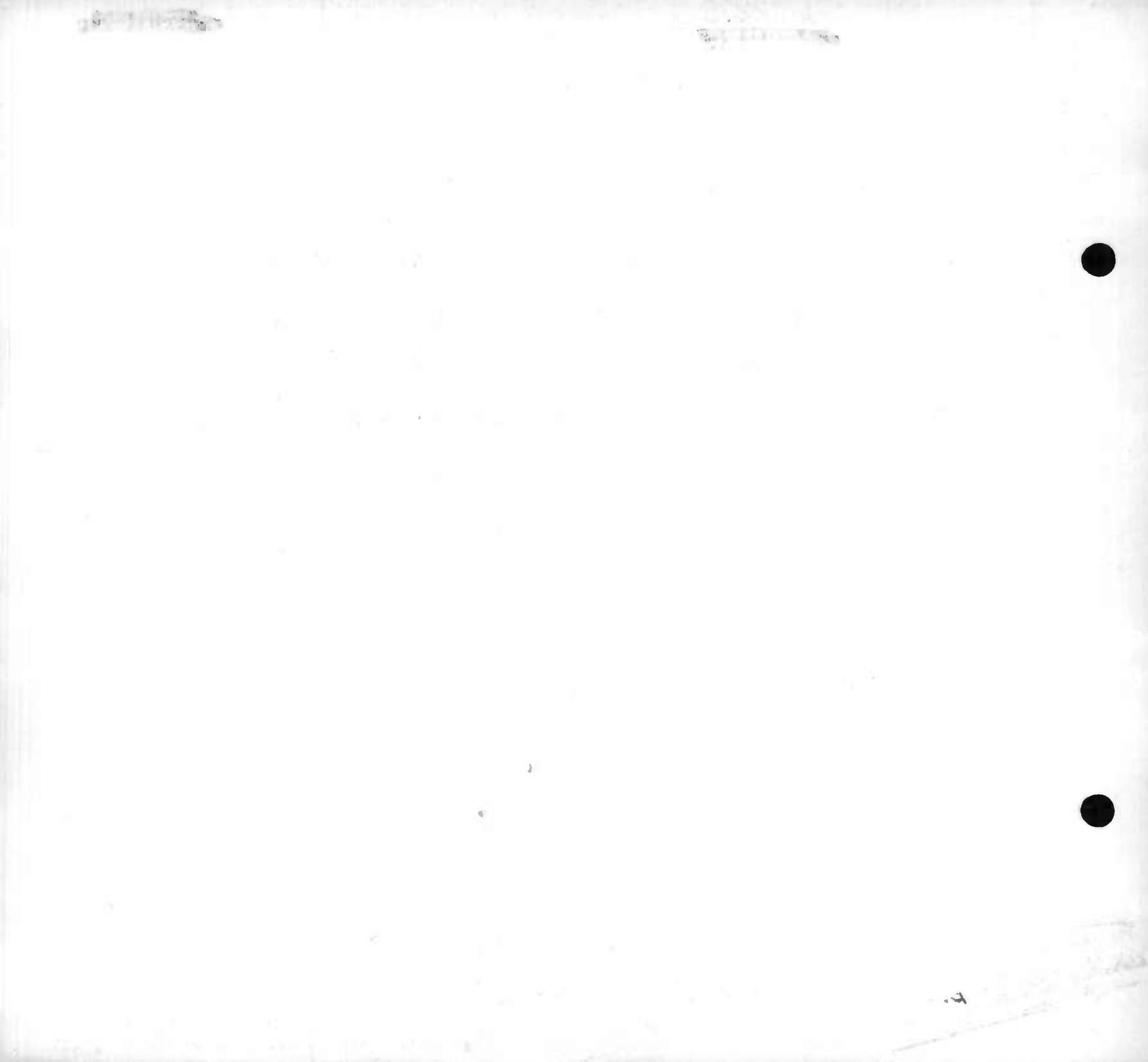
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**FUNERAL DIRECTOR: IMPORTANT**

G 650  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH												REG. NO. 71 12278
BIRTH NO. 1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH December 28, 1971 12:35 P.M.									
Carrie GREEN												
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  90			(If not in hospital or institution, give street address or location) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909						
5. SEX F 6. RACE B			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/22/1913 9. AGE (in years last birthday) 58			II Under 1 Yr. Days Months Hours III Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) N.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sherman Parsons			14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-09-2498 17. INFORMANT COLLIN T. GREEN 1312 N. Caroline St.			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH C.V.A.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			(B) DUE TO, OR AS A CONSEQUENCE OF: A.S. C.V.D.			(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			20. AUTOPSY (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 June 1970 to December 28, 1971 that (I) (we) last saw the deceased alive on 12/21/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Joseph S. Blum, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/29/71						
23C. PHYSICIAN'S NAME (Type) Joseph S. Blum, M.D.		23D. ADDRESS 1115 K. CALVERT ST.										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71		24C. NAME of CEMETERY or CREMATORIUM Arbutus Memorial Park		24D. LOCATION (City, town, or county) Arbutus, Maryland						
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collier		ADDRESS 2431 E. Oliver St.						



## FUNERAL DIRECTOR: IMPORTANT

S 563  
71 12277 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH  
REG. NO. 71 12277

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

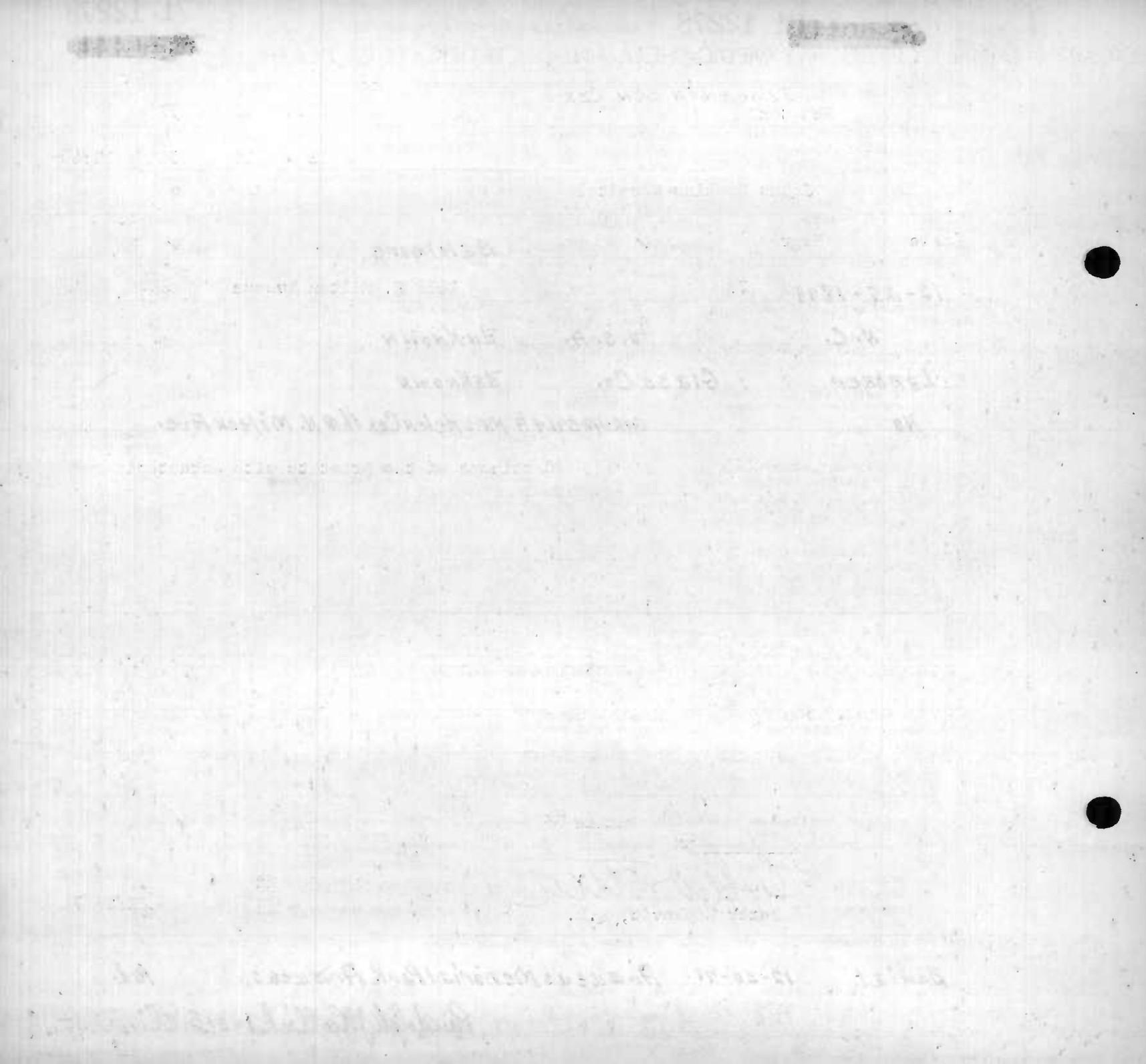
BIRTH NO.	2. DATE AND HOUR OF DEATH 12 - 30 - 71 1:30 P.M.		
1. NAME OF DECEASED (Type or Print) <i>Smart - Amelia</i>	4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 1606		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bolton Hill Nursing Home</i>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1896 9. AGE (in years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>Hampshire, S.C.</i>
10B. KIND OF BUSINESS OR INDUSTRY At Home	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME Charles Smith	
14. MOTHER'S MAIDEN NAME Mary Gray	15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>	16. SOCIAL SECURITY NO. <i>267-30-7292</i>	17. INFORMANT Mrs. Nellie Rogers 1312 N. Broadway
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac failure</i>		 <i>Years</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis generalized</i>		 <i>Years</i>	
(C) <i>Emphysema</i>		 <i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12/6 1968 to 12/30 1971 that (I) (we) last saw the deceased alive on 12/30 1971 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>A. Smart</i>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <i>12/31/71</i>
23C. PHYSICIAN'S NAME (Type) <i>Alvin H. MacIntosh MD</i>		23D. ADDRESS <i>26 Read St. Bldg. 200</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1-3-72</i>	24C. NAME OF CEMETERY or CREMATORIAL DEGREE <i>Md. National Park</i>	24D. LOCATION (City, town, or county) (State) <i>Laurel, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1972</i>	25B. NAME OF REGISTRAR <i>Robert E. Barber, M.D.</i>	25C. FUNERAL DIRECTOR <i>Pandolph Collick</i>	ADDRESS <i>2431 E. Oliver St.</i>

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Address,

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71 12278 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. [REDACTED]

BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		Benjamin Ben Cox					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION [REDACTED] 33		Johns Hopkins Hospital					
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2. DATE OF DEATH Estimated <input type="checkbox"/>	Known <input checked="" type="checkbox"/> Month 12 Year 71	Day 26	Year 71	Hour M.
9. DATE OF BIRTH 12-25-1899	10. AGE (In years lost birthday) 72	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	3. DATE PRONOUNCED DEAD 12	Month 26	Day 71	Year 12:40a	Hour M.
11. BIRTHPLACE (State or foreign country) N.C.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.		B. COUNTY 802			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY Glass Co.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		17. SOCIAL SECURITY NO. 242-42-57648		E. STREET AND NUMBER 1618 N. Milton Avenue		15. MOTHER'S MAIDEN NAME Unknown	
19. 185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carcinoma of the prostate with metastasis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) _____					
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> m.		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> EXAMINER'S NAME (Type) Peter Lipkovic, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-71		24C. NAME OF CEMETERY or CREMATORIUM Arbutus Memorial Park Arbutus,		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert Erzberger, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	



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71 12279

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12279

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THELMA ROBINSON

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

614 Collett St.

6. SEX  
female7. RACE  
negro8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 9. DATE OF BIRTH  
1-10-3310. AGE (In years  
last birthday) 3911. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

NORFOLK VA

12. CITIZEN OF  
U.S.A.14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL SECURITY NO.  
UNKNOWN18. INFORMANT  
ROSA MOSES 812 ADDRESS  
S.E. WASH.

19. 282

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK  NOT WHILE  
AT WORK 

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

12-13-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)24B. DATE  
12-18-71 Mt. Calvary

24C. NAME of CEMETERY or CREMATORI

24D. LOCATION (City, town, or county) (State)  
Edenhill Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR  
Robert E. Fisher, M.D.25C. FUNERAL DIRECTOR  
Wesley Davis Jr. 1922 Edgewood Ave

ADDRESS

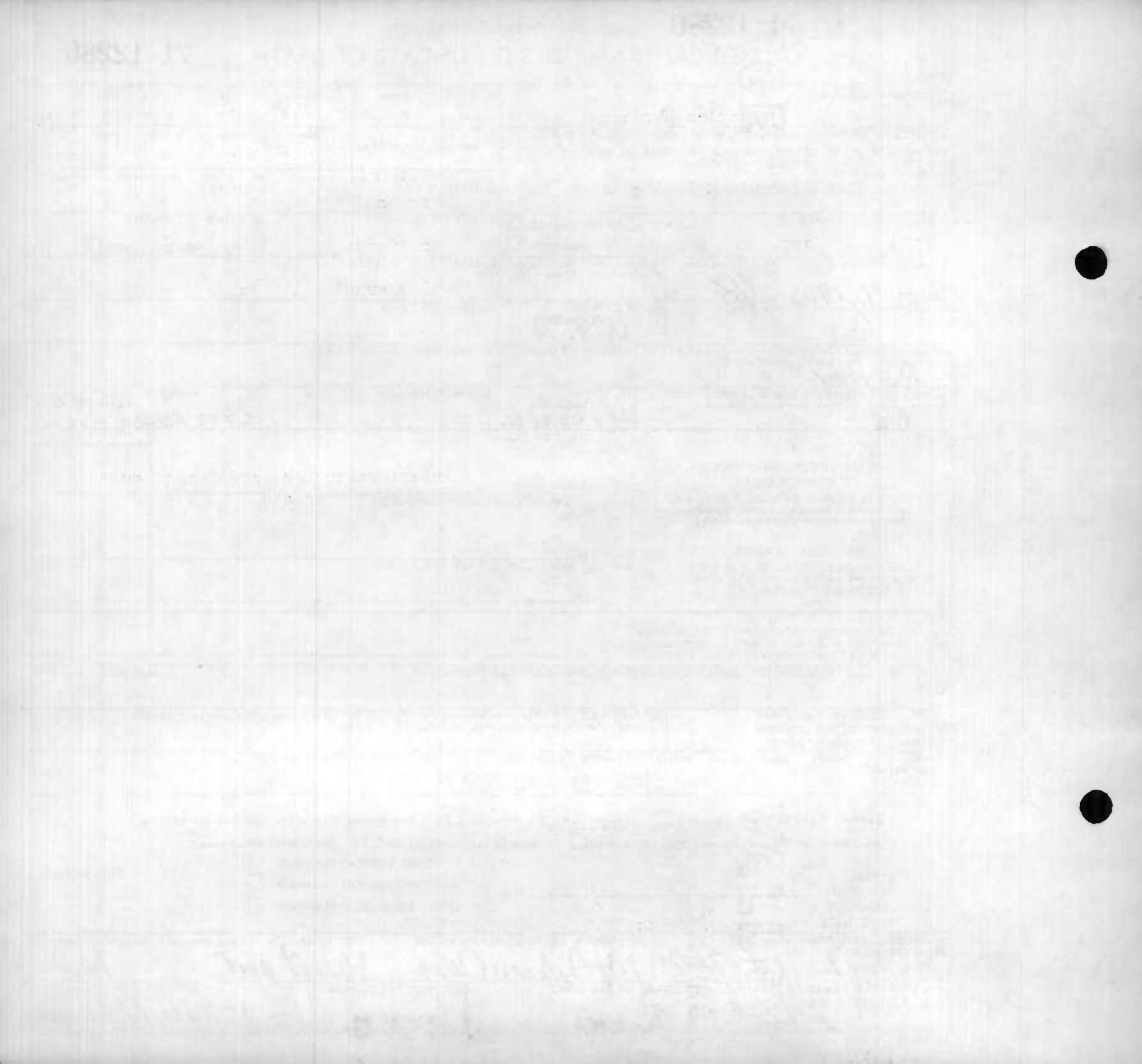
1-13-1972 Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

1 B-636 71 12280 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12280

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Charles Borders		2. DATE OF DEATH	Known <input checked="" type="checkbox"/> Month 12	Day 28	Year 71	Hour 10:30 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  OO		(If not in hospital or institution, give street address or location) 1102 Druid Hill Avenue		3. DATE PRONOUNCED DEAD	Estimated <input type="checkbox"/> Month 12	Day 28	Year 71	Hour 10:30 A.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Sept 4, 1903		10. AGE (In years last birthday) 89	If Under 1 Yr. <input type="checkbox"/> Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	E. STREET AND NUMBER 1102 Druid Hill Avenue				
11. BIRTHPLACE (State or foreign country) Ga		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Lewis William Borders				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Ida Carter	ADDRESS Mrs Berneta Lawyer 6445 Lorzen Ave N.W. Wash D.C.			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		17. SOCIAL SECURITY NO. 084-03-6632		18. INFORMANT Mrs Berneta Lawyer	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:						
20A. DATE OF OPERATION O		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				DATE SIGNED 12-28-71				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-71	24C. NAME of CEMETERY or CREMATORIAL Mt Auburn Cemetery	24D. LOCATION (City, town, or county) Westport				
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR R. L. Spitz, M.D.		25C. FUNERAL DIRECTOR Joseph J. Russ 2222 W. North Ave				
				ADDRESS				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-151		71 12281		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 12281	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)		William E. Davenport				2. DATE AND HOUR OF DEATH 12/24/71		6 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY HOWARD		6300	
90 Mt Sinai Nursing Home				C. CITY OR TOWN Waterloo		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 13, 1889		9. AGE (in years lost birthday) 82 83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Northumberland Va		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME James Davenport				14. MOTHER'S MAIDEN NAME Lucy Benns					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 227-07-6678		17. INFORMANT Clinton Davenport 7310 Wye Ave		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. I 185 X I		CAUSE OF DEATH		(A) IMMEDIATE CAUSE Carcinoma of Prostate		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloing the UNDERLYING CONDITION lost.				(C) _____					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?				(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E.S. Kallins MD		23B. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. DATE SIGNED 11/3/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6000 PARK H B AY BALTIMORE MD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-28-71		24C. NAME OF CEMETERY OR CREMATORIAL DEGREE		24D. LOCATION BURGESS		(City, town, or county) (State) 1/4	
Burial		12-28-71		Shiloh Baptist Ch. Cem					
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR Robert E. Kallins		25C. FUNERAL DIRECTOR		ADDRESS 1100 Park Hi-Rise 2222 W. North Ave			
VS 150-REV. 1/1/68									

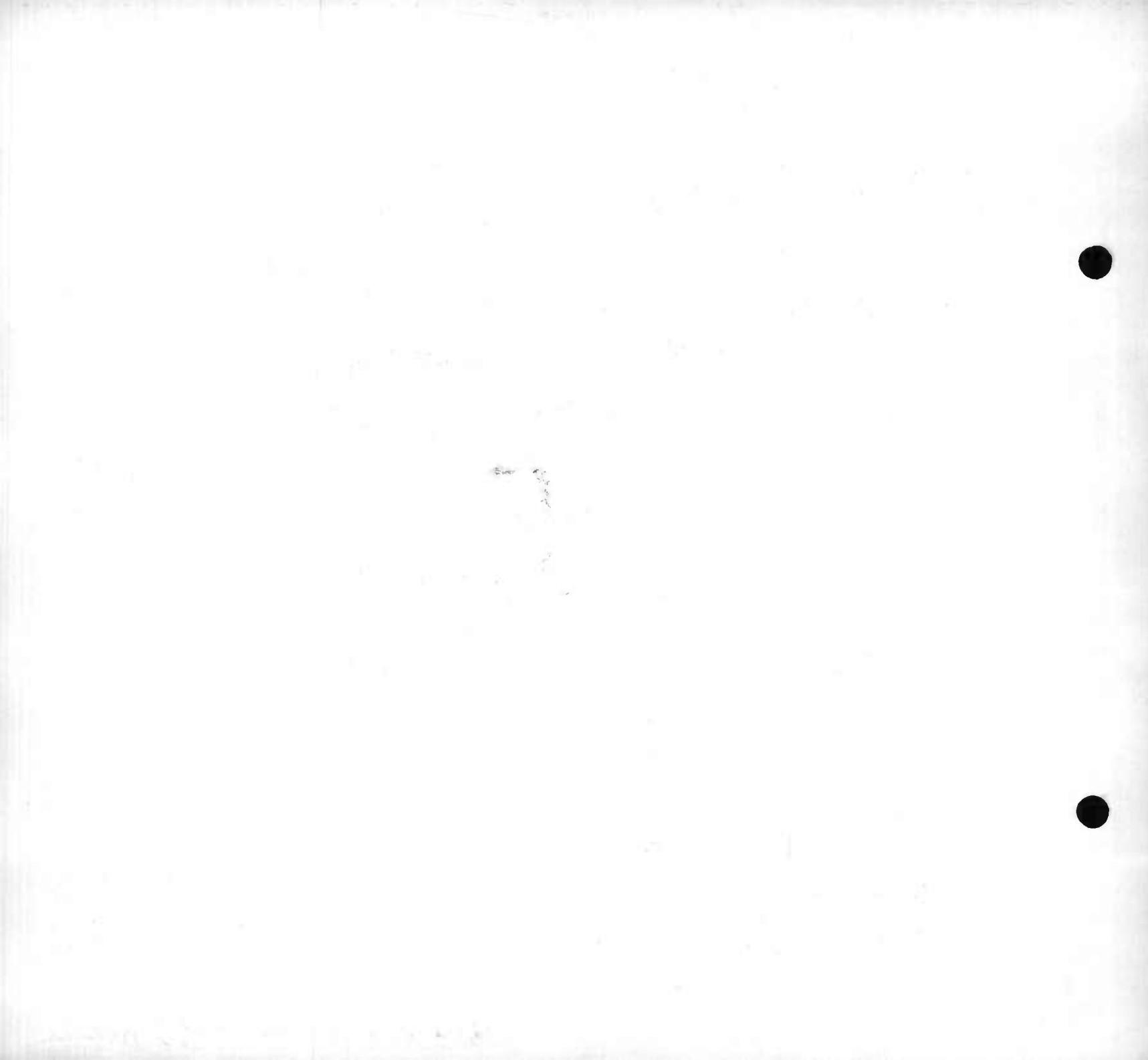


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**MEDICAL CERTIFICATION**

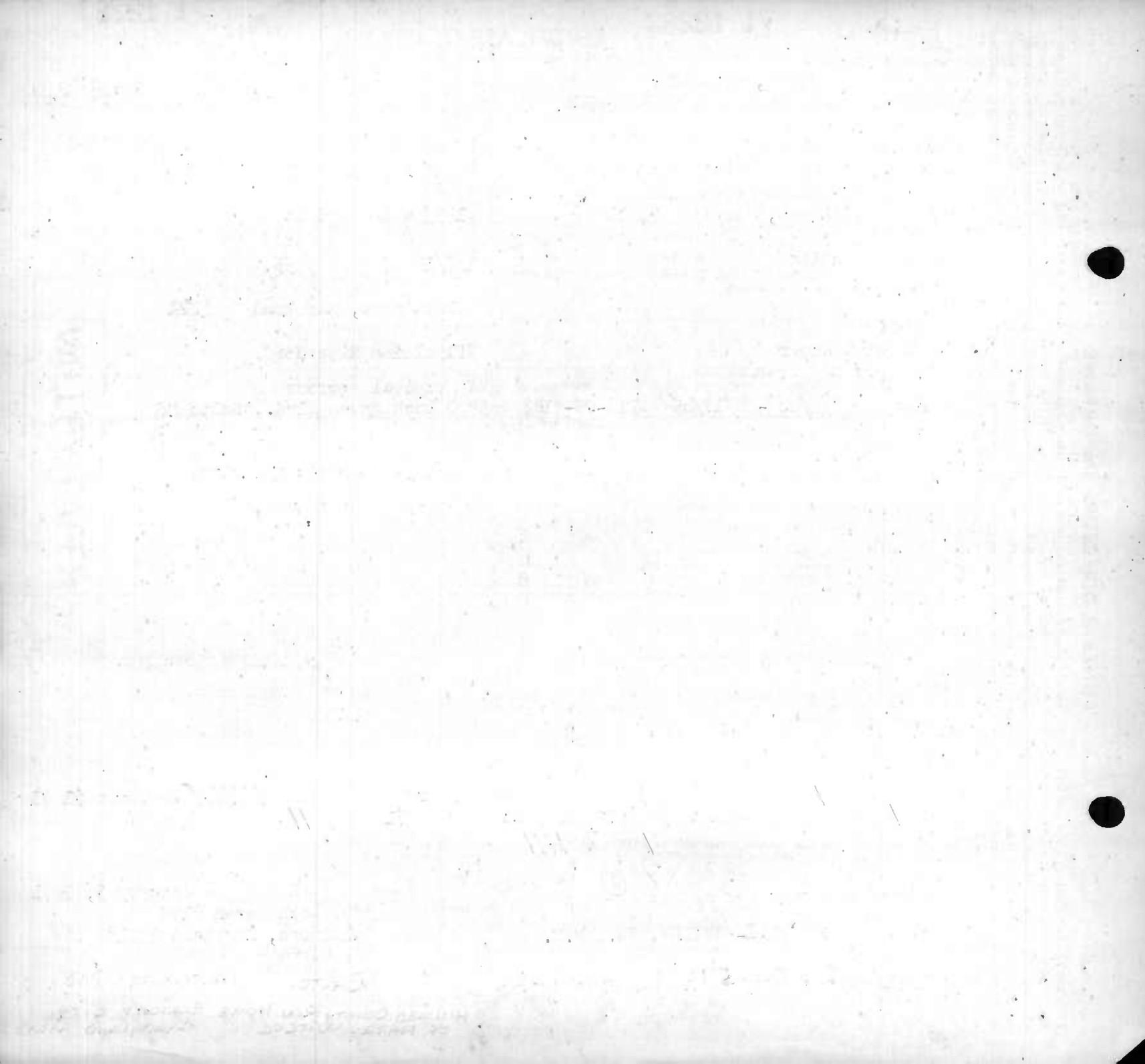
1. NAME OF DECEASED (Type or Print)		71 12282		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 12282																																																																																																													
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 12-26-71 2 PM																																																																																																															
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																																																																																																															
PROVIDENT HOSPITAL BALTIMORE MD 21216				A. STATE Md		B. COUNTY 1403		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2127 ETTING ST.				E. STREET AND NUMBER				5. SEX F	6. RACE NW	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/78	9. AGE (in years last birthday) 93	II Under 1 Yr. Months	II Under 24 Hrs. Days	II Under 24 Hrs. Min.	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Md, U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE JOHNSON		14. MOTHER'S MAIDEN NAME WATSON-Mary Catherine Watson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-9225		18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH ACUTE INFERIOR MYOCARDIAL INFARCTION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HOURS		ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Failure		(C) Congestive Failure		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. PULMONARY EDEMA						21A. DATE OF OPERATION 11/1/71		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR?		21D. HOW DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROXJ		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				22. I certify that (1) (this hospital) attended the deceased from 11-29-1971 to 12-26-1971 that (1) (we) last saw the deceased alive on 12-25-1971 and that In my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.								23A. SIGNATURE Richard Tyson, M.D.		23B. DATE SIGNED 12-26-71		23C. PHYSICIAN'S NAME (Type) RICHARD TYSON, M.D.		23D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23E. ADDRESS 936 W. NORTH AV. BALTIMORE 21217 MD.		24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 12/29/71 MFT Aub C		24C. NAME OF CEMETERY or CREMATOR Y		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph & Russ		ADDRESS 2222 W. North St.	
A. STATE Md		B. COUNTY 1403		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																																																													
E. STREET AND NUMBER 2127 ETTING ST.				E. STREET AND NUMBER																																																																																																															
5. SEX F	6. RACE NW	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/78	9. AGE (in years last birthday) 93	II Under 1 Yr. Months	II Under 24 Hrs. Days	II Under 24 Hrs. Min.																																																																																																												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Md, U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.																																																																																																													
13. FATHER'S NAME GEORGE JOHNSON		14. MOTHER'S MAIDEN NAME WATSON-Mary Catherine Watson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-9225																																																																																																													
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH ACUTE INFERIOR MYOCARDIAL INFARCTION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HOURS																																																																																																															
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Failure		(C) Congestive Failure																																																																																																													
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. PULMONARY EDEMA																																																																																																																	
21A. DATE OF OPERATION 11/1/71		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR?		21D. HOW DID INJURY OCCUR?																																																																																																													
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROXJ		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																																																																																																															
22. I certify that (1) (this hospital) attended the deceased from 11-29-1971 to 12-26-1971 that (1) (we) last saw the deceased alive on 12-25-1971 and that In my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.																																																																																																																			
23A. SIGNATURE Richard Tyson, M.D.		23B. DATE SIGNED 12-26-71																																																																																																																	
23C. PHYSICIAN'S NAME (Type) RICHARD TYSON, M.D.		23D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23E. ADDRESS 936 W. NORTH AV. BALTIMORE 21217 MD.																																																																																																															
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 12/29/71 MFT Aub C		24C. NAME OF CEMETERY or CREMATOR Y		24D. LOCATION (City, town, or county) (State)																																																																																																													
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph & Russ		ADDRESS 2222 W. North St.																																																																																																													



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

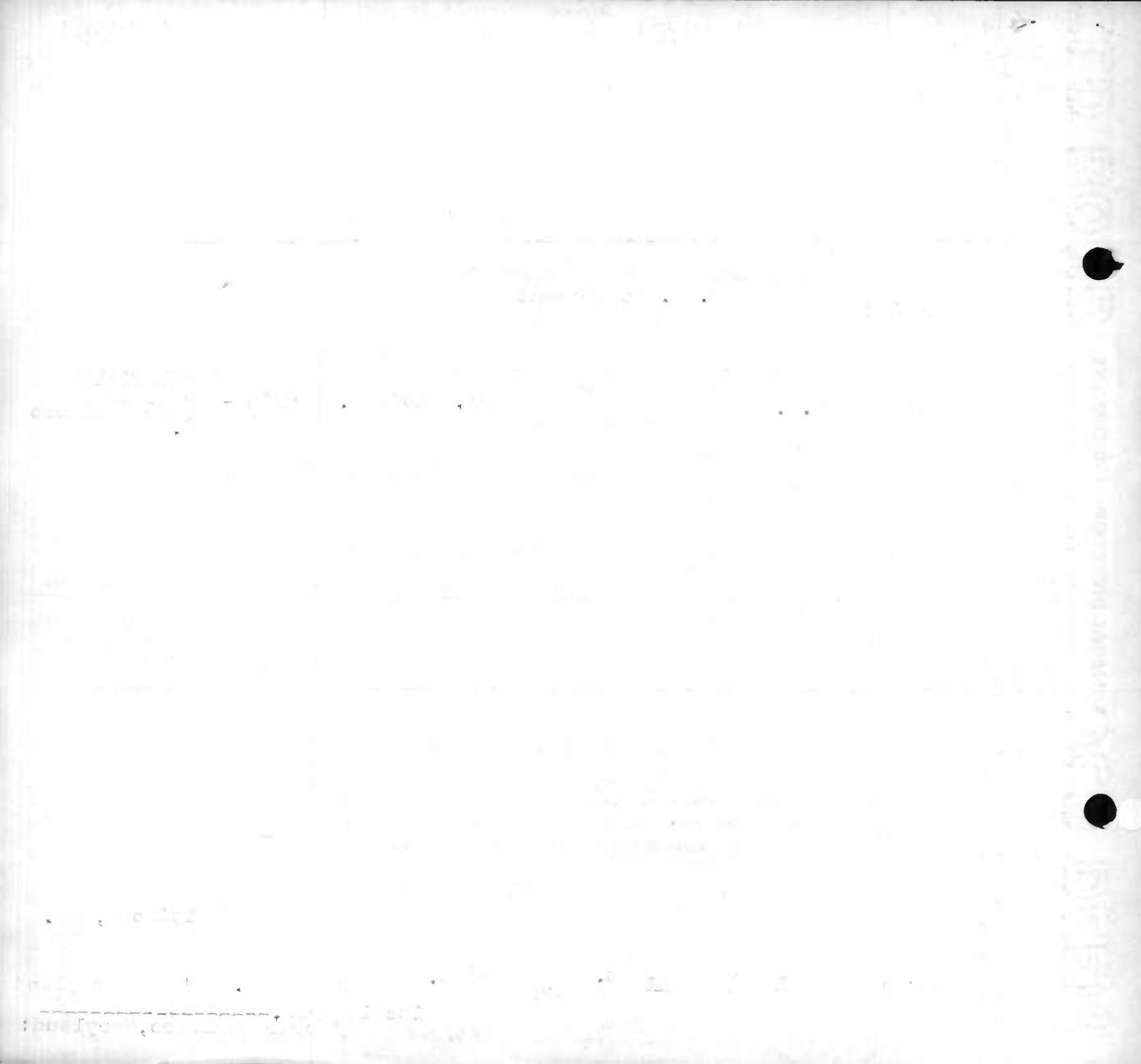
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		71 12283		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____		71 12283	
KNORR, WILLIAM F				CERTIFICATE OF DEATH					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			2. DATE AND HOUR OF DEATH						
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		December 31, 1971   10:15 P M.					
23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218							1903		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1903						
Male	White								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH			9. AGE (In years lost birthday)	If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.	
				1/5/16			55		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Baltimore, Maryland			USA						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
Ernest A Knorr			Wilhelmina Ringsdorf						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
Yes 2/9/42 - 6/17/45		218-05-2188		VA Hospital Records 3900 Loch Raven Blvd., Balt. Md					
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Rupture Aortic aneurism DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:						
			(C) _____						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
MEDICAL CERTIFICATION		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from October 3rd 1971 to January December 31 1971, that (I) (we) last saw the deceased alive on December 31st 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) / did not view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED							
<i>Antonio Gonzalez-Revilla, Jr., M.D.</i>		January 3, 1971							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
ANTONIO GONZALEZ-REVILLA, JR., M.D. DEGREE		3900 Loch Raven Blvd Baltimore, Maryland 21218							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIAL		24D. LOCATION (City, town, or county)		(State)	
CREMATION JAN 5 '72				LOUDON PARK		BALTO.		BALTO. CITY, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 10 1972		V. J. G. R. A. D.		HOWARD COUNTY FUN. HOME ELICOTT CITY OF HAROLD WITZKE		MARYLAND 21043			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

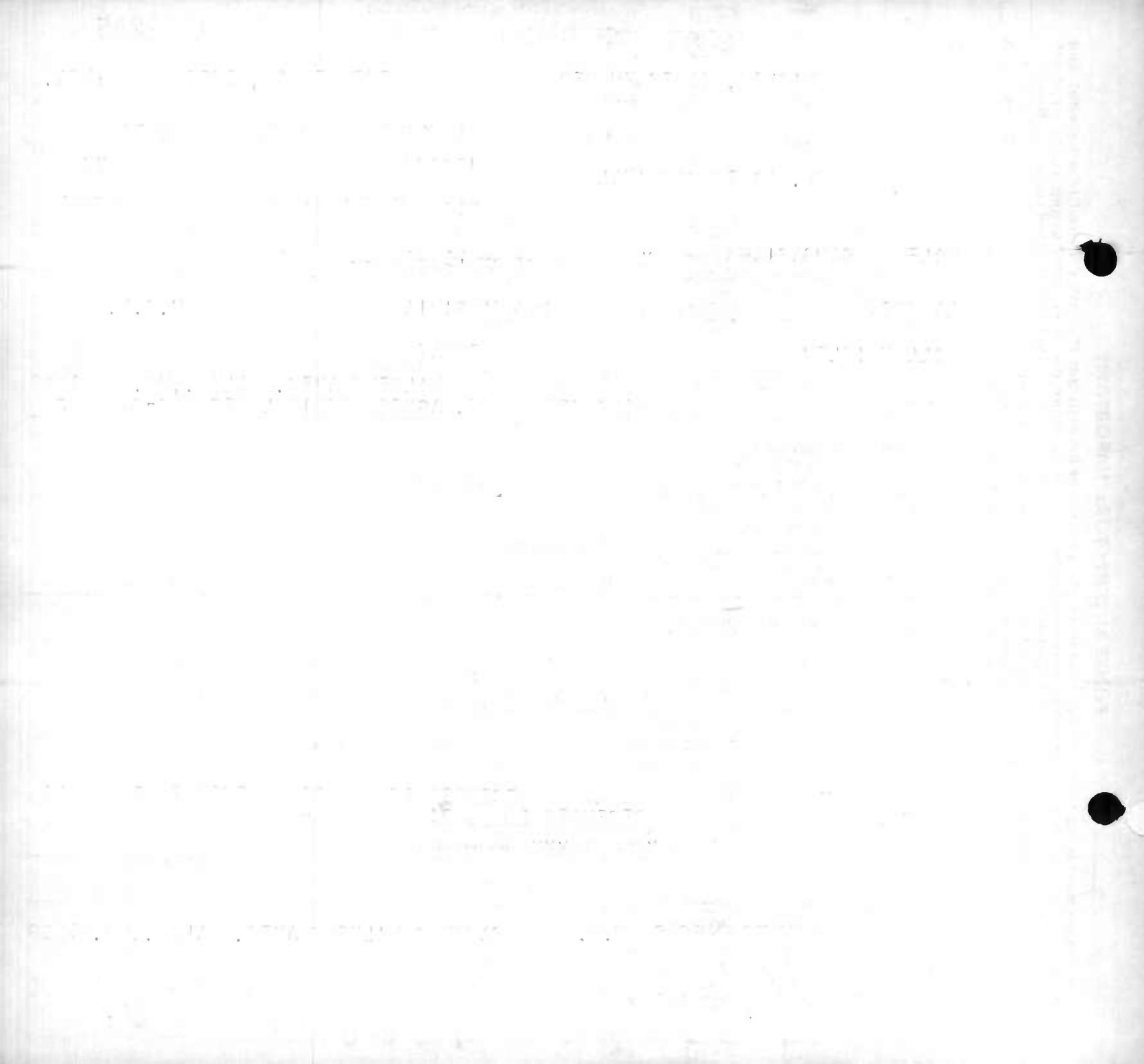
B-452 BIRTH NO.		71 12284 CERTIFICATE OF DEATH X		REG. NO. 71 12284	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Dec. 30. 71 1 12 <sup>10</sup> P.M.			
John D. Jr					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland P.G B. COUNTY 6600			
FULL NAME OF HOSPITAL OR INSTITUTION  UNION MEMORIAL HOSPITAL		C. CITY OR TOWN Upper Marlboro D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-27-95 9. AGE (in years last birthday) 76 If Under 1 Yr. Months: Days: Hours: Min:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10B. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John D. Bowling		14. MOTHER'S MAIDEN NAME Mildred Nalle		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes W.W. I		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rhoda C. Bowling- "Bellevue Field" Box 3800 Upper Marlboro Md.	
18. 15-3.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death)		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARCINOMA TORS DUE TO, OR AS A CONSEQUENCE OF:  (B) CA. OF colon DUE TO, OR AS A CONSEQUENCE OF:  (C).  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indly medical examined)		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-29-71 19 to 12-30-71 19 that (I) (we) last saw the deceased alive on 12-30-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DEGREE MD		23C. ATTENDING PHYSICIAN Jairo Ramirez MD	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNION MEMORIAL HOSPITAL		23E. DATE SIGNED 12-30-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/72		24C. NAME OF CEMETERY OR CREMATORY St. Thomas Episc. Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 10 1972		25B. NAME OF REGISTRAR Robert J. Schlesinger		25C. FUNERAL DIRECTOR Ritchie Bros. Mortuary Upper Marlboro, Maryland	
VS 150-REV. 1/1/68					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K-524		71 12285	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12285
1. NAME OF DECEASED (Type or Print) <b>KNISLEY, JAMES TURNER</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 30, 1971, 2:45A.M.</b>			
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, If institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>		5. 20794 6300	
		C. CITY OR TOWN <b>JESSUP</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>7150 MONTIVEDO ROAD</b>		20794	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09 13 92</b>	9. AGE (in years last birthday) <b>79</b>	If Under 3 Yrs. Months Days Hours If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STATE OF MD</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>WILL KNISLEY</b>		14. MOTHER'S MAIDEN NAME <b>EMMA ( ) LICHITER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>NO</b>		16. SOCIAL SECURITY NO. <b>217505780</b>		17. INFORMANT <b>WILKENS AVES. BALTO., MD. 21229</b>	
18. <b>16311</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <b>Bronchogenic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 15 1971</b> to <b>DECEMBER 30 1971</b> shot <input type="checkbox"/> (he) (she) last saw the deceased alive on <b>DECEMBER 30 1971</b> and that In <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>Donato A. Vargas Jr.</b>		23B. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. DATE SIGNED <b>13-30-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONATO VARGAS M.D.</b>		23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/1/72</b>		24C. NAME OF CEMETERY or CREMATORIAL <b>Meadamitylge Mem Park Cemetery Maryland</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 12 1972</b>		25B. NAME OF REGISTRAR <b>22</b>		25C. FUNERAL DIRECTOR <b>J. H. Laurel, Jr.</b>	
VS 150-REV. 1/1/68					



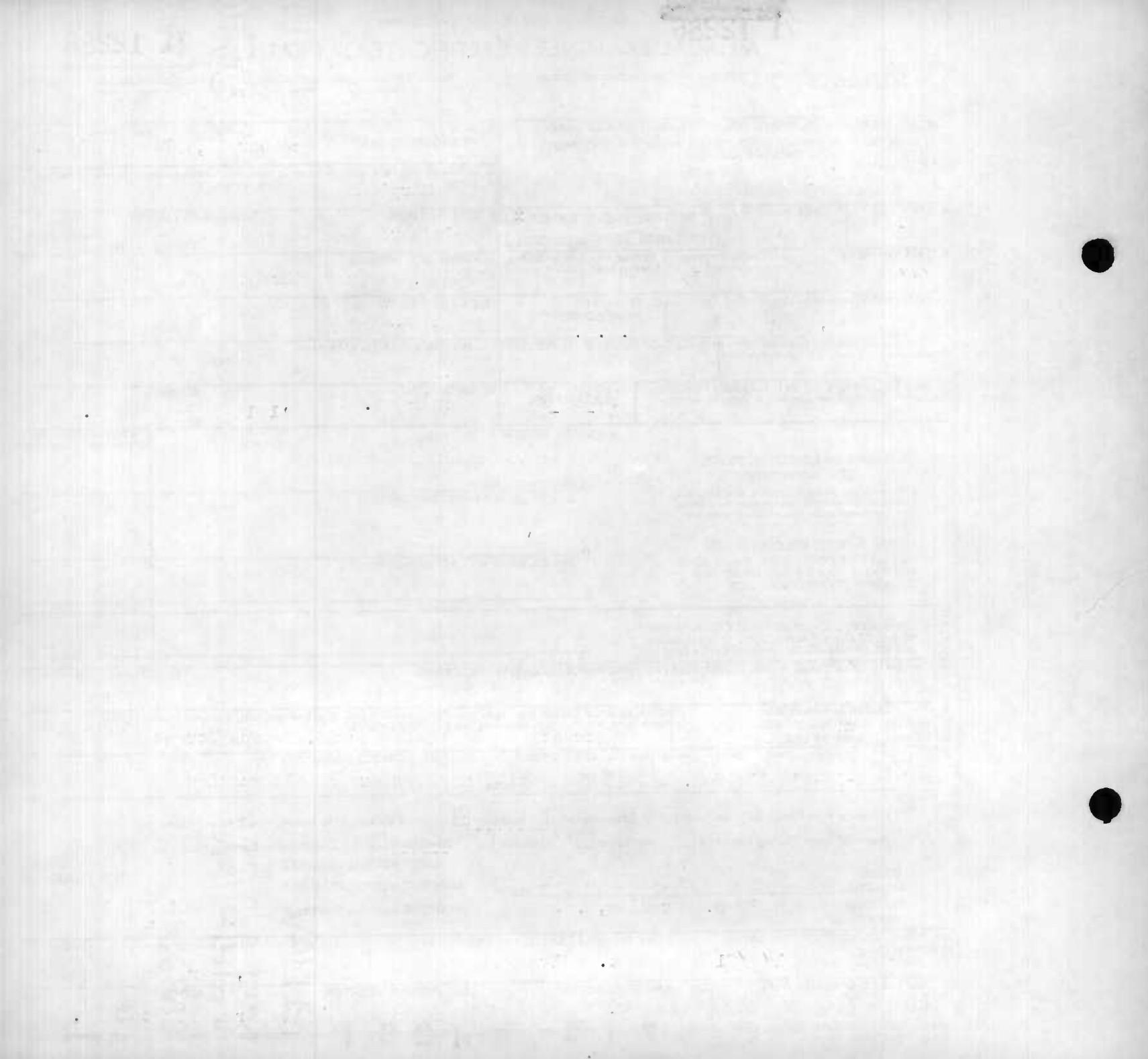
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12286

BIRTH NO.

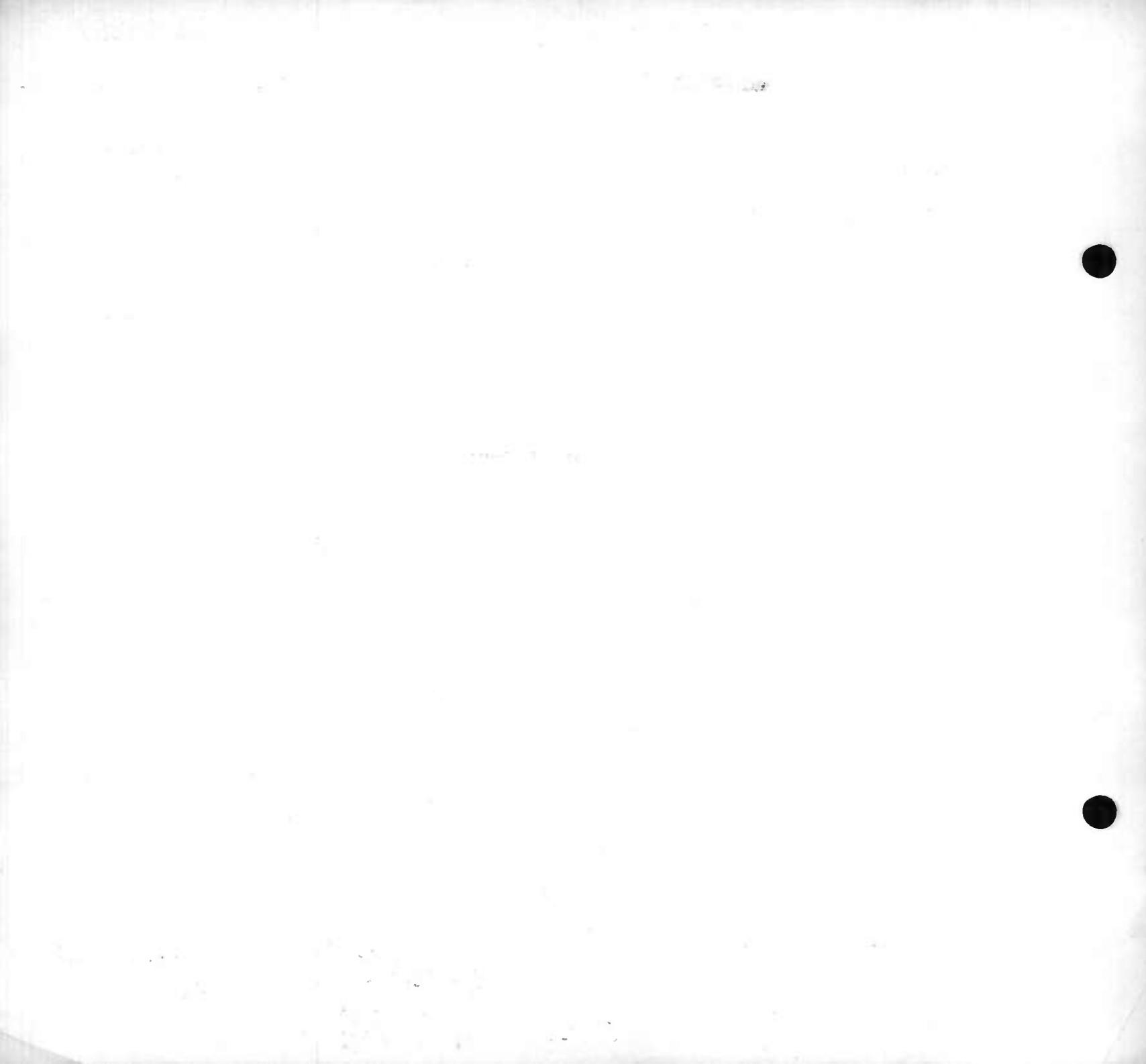
1. NAME OF DECEASED (Type or Print)		CHARLES CHASE		2. DATE OF DEATH	Known <input type="checkbox"/> Month	Day	Year	Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Estimated <input type="checkbox"/>	M.				
34 BON SECOURS HOSPITAL				3. DATE PRONOUNCED DEAD	Month	Day	Year	Hour	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	M.						
9. DATE OF BIRTH 9/5/52		10. AGE (In years lost birthday) 19	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	M.					
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Chase					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Katie Hall					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-56-2835		18. INFORMANT Richard A. Chase, 1916 Saratoga St. ADDRESS					
MEDICAL CERTIFICATION	19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</small>		CAUSE OF DEATH Gunshot wound of abdomen				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCURRED 500 Block N. Payson Street		1604			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-30-71 11:45 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation					
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Ronald N. Kornblum, M.D.</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.</p>									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/72	24C. NAME OF CEMETERY or CREMATORIUM Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 14 1972		25B. NAME OF REGISTRAR Ref. A. Bailey, Jr.		25C. FUNERAL DIRECTOR Kenneth Law 4611 Park Heights Ave.			ADDRESS		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-656 BIRTH NO. 71-21770		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12287	
1. NAME OF DECEASED (Type or Print) Baby Boy [REDACTED] Cramer		2. DATE AND HOUR OF DEATH December 29, 1971		16:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2664		
5. SEX Male 6. RACE Caucasian			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Mary Jane		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. AUTOPSY? (Yes or No) Yes 19D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) 1 Day (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 12/27 1971 to _____ 12/29 1971 that (I) (we) last saw the deceased alive on _____ 12/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  B. Zetelli, M.D.			23B. DATE SIGNED 12/29		
23C. PHYSICIAN'S NAME (Type) B. Zetelli, M.D.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12-31-71		24C. NAME OF CEMETERY OR CREMATORIAL Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland 21224					
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Babey, Jr.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	
ADDRESS					



1  
H-320  
71 12288 BALTIMORE CITY HEALTH DEPARTMENT

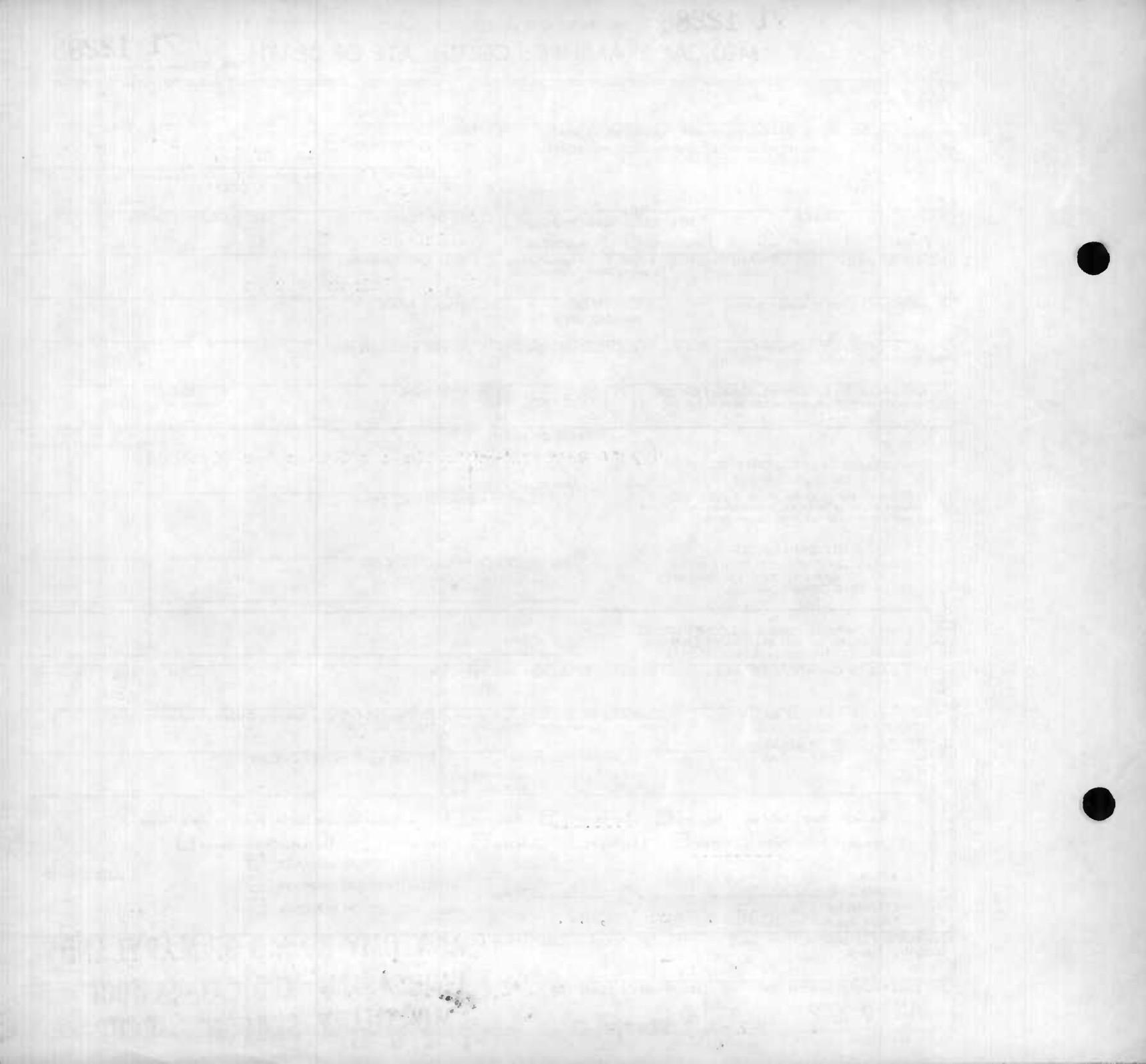
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12288

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY HADDOX			2. DATE OF DEATH Known <input type="checkbox"/> Month _____ Day _____ Year _____ Estimated <input type="checkbox"/> Hour _____ M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  35 CHURCH HOME AND HOSPITAL			3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____ December 18, 1971 11:10 A.M.
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH		10. AGE (In years last birthday) 64	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS
MEDICAL CERTIFICATION	19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		
	CAUSE OF DEATH Arteriosclerotic cardiovascular disease		
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
	(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20C. AUTOPSY? (Yes or No) No		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-6-72	
24C. NAME OF CEMETERY or CREMATORIUM AND ADDRESS		24D. CEMETERY or CREMATORIUM AND ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1972		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL Crematory Director ADDRESS MORTUARY SERVICE - BCMD			



71 12289

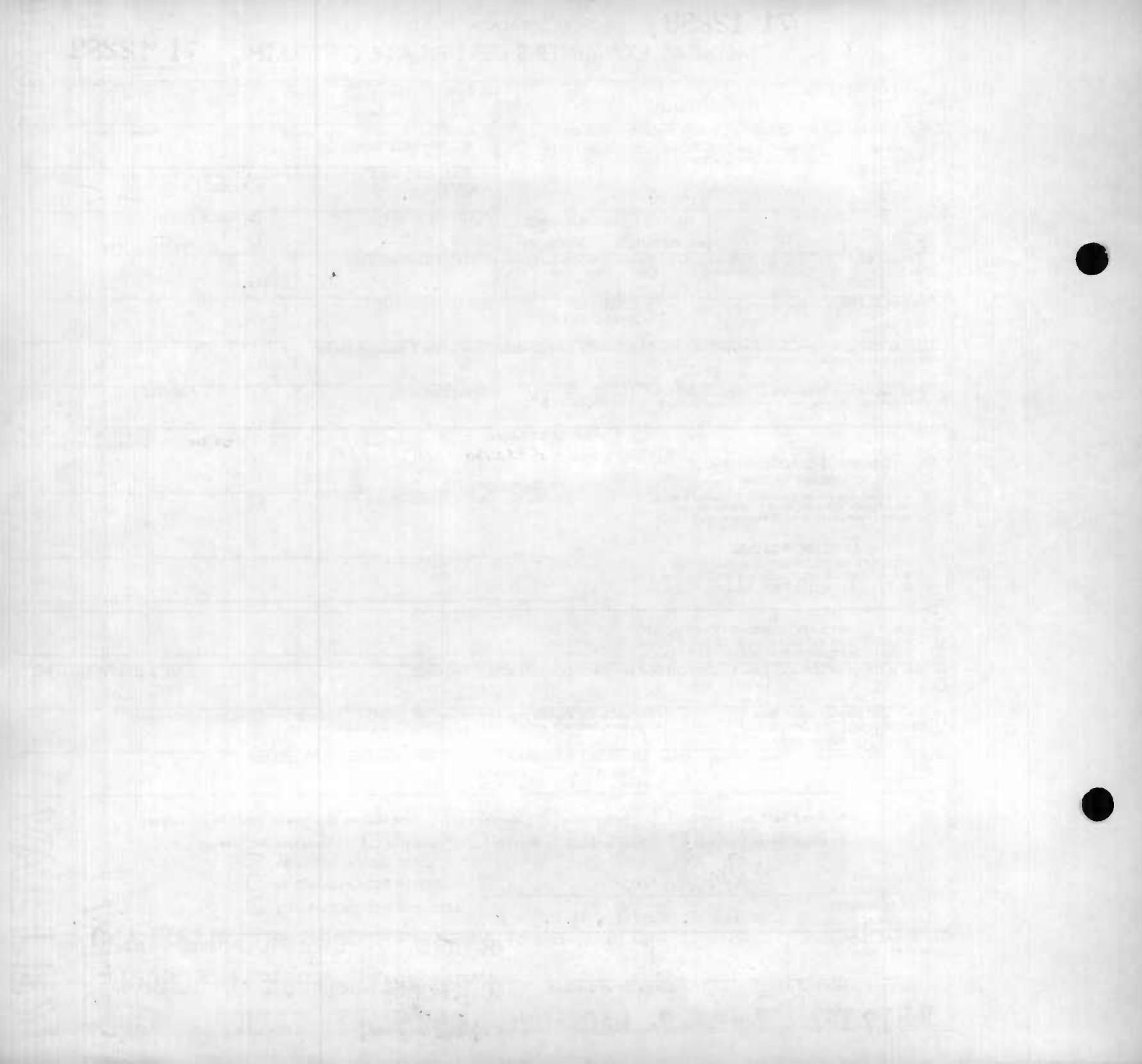
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 12289  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		HOWARD HOANEY		2. DATE OF DEATH	Known <input type="checkbox"/> Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Estimated <input type="checkbox"/>				M.
		OO 616 Springfield Ave.		3. DATE PRONOUNCED DEAD	Month	Day	Year	Hour
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11	22	1971	6:45 a.m.
9. DATE OF BIRTH		10. AGE (In years last birthday) 65	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	E. STREET AND NUMBER 616 Springfield Ave.		13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT		ADDRESS			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</small>		CAUSE OF DEATH Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C) _____						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, lotary, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED 11-22-71								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-6-72	24C. NAME of CEMETERY or CREMATORIUM	24D. LOCATION (City, town or county)	24E. STATE (State)	UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR R. S. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS				
VS 151-REV. 1/1/68								



BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12290

1. NAME OF DECEASED  
(Type or Print)

UNKNOWN

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
*OO*(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

619 Pierce Street

6. SEX

Male

7. RACE

Negro

8. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

9. DATE OF BIRTH

10. AGE (in years  
lost birthday)

? 60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

C. CITY OR TOWN

E. STREET AND NUMBER

13. FATHER'S NAME

D. INSIDE CITY LIMITS?

YES  NO 14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19. *796-19*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

UNDETERMINED (due to advanced  
post mortem decomposition)APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
Yes22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK   
m. NOT WHILE AT WORK 

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry  Inspection  Autopsy  and that on this basis, death in my opinion  
resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)*Charles S. Springate, M.D.*  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER 

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

January 11, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

1-13-72

24C. NAME OF CEMETERY or CREMATORIUM

24D. LOCATION (City, Town or County)

ANATOMY BOARD OF MARYLAND

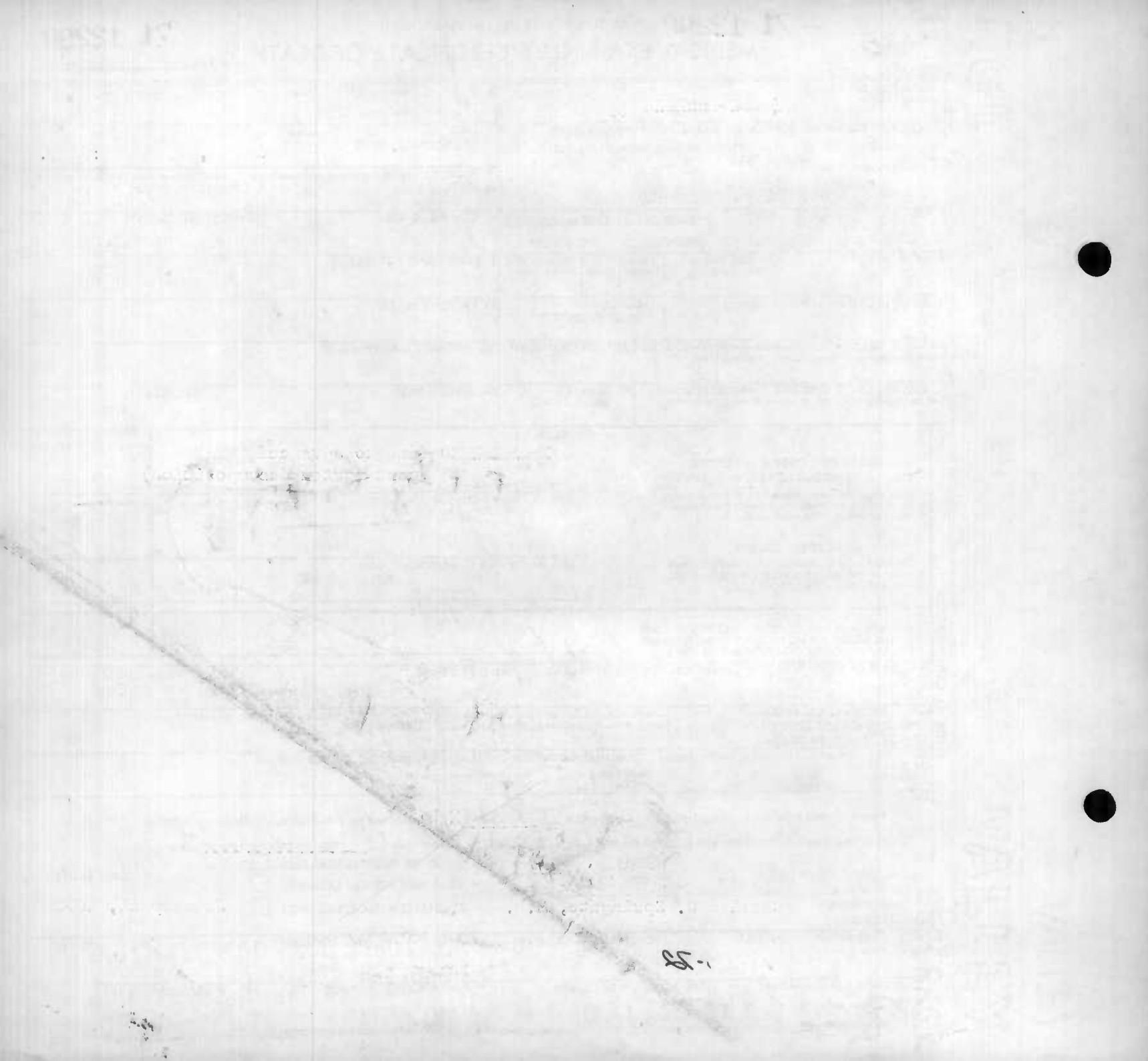
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 17 1972 *Charles S. Springate, M.D.*UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE BCHD



1  
U-52571 12291

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12291

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)UNKNOWN  
( UNIDENTIFIED )2. DATE Known  Month Day Year Hour  
OF DEATH Estimated 

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
00(If not in hospital or institution, give street  
address or location)  
Found floating in water off  
2700 block Boston Street

3. DATE PRONOUNCED DEAD Month Day Year Hour

April 14, 1971 5:05 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Month Day Year Hour

S. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

00-00

6. SEX

Male

7. RACE ?

8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

C. CITY OR TOWN

D. INSIDE CITY LIMITS?  
YES  NO 

9. DATE OF BIRTH

10. AGE (In years  
lost birthday) 60 ?

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

E. STREET AND NUMBER

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19. E7841 X

DISEASE OR CONDITION DIRECTLY

LEADING TO DEATH

(This does not mean the mode of dying, e.g.,

heart failure, asthma, etc. It means the disease,

injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING

RISE TO THE ABOVE CAUSE (A) STATING THE

UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Found in water, presumably drowned

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE TERMINAL

DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

d

22A. EXTERNAL CAUSE WAS

UNDERLYING  OR CONTRIB-UTING  CAUSE OF DEATH.

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY  
(APPROX.)

? m.

WHILE AT WORK NOT WHILE AT WORK 

? ?

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry Inspection Autopsy 

and that on this basis, death in my opinion

resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

JAN 17 1972 Robert E. Barber, M.D.

N 9977

MORTUARY SERVICE - BCFD

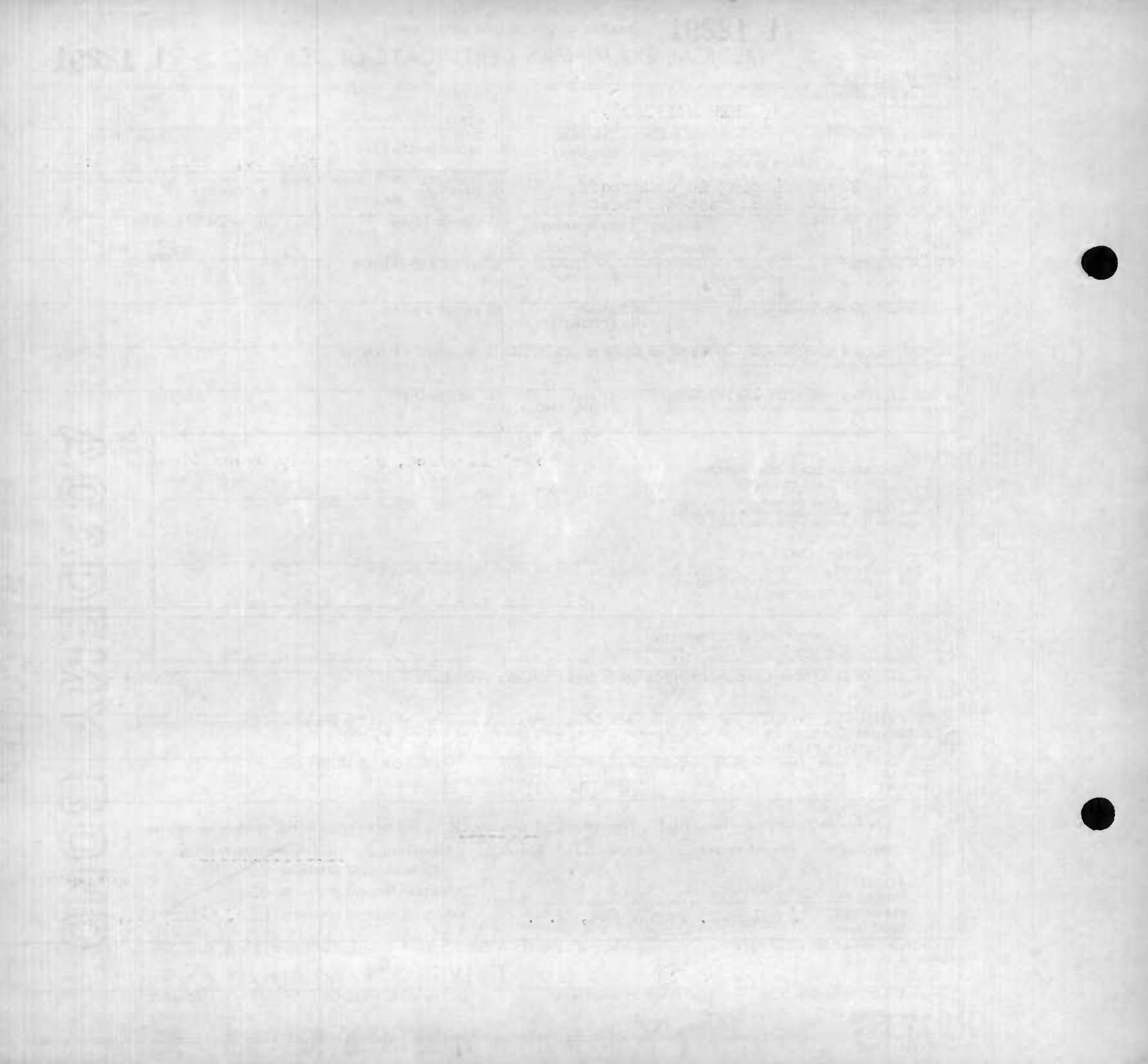
VS 151-REV. 1/1/68

N 9977

100

MORTUARY SERVICE - BCFD

N 9977



## DUPLICATE COPY

DUPLICATE COPY

520  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

DUPLICATE COPY

71 12292

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 12292

BIRTH NO.  
(Type or Print)

Margaret M. LEMKE

2. DATE AND HOUR OF DEATH

December 29, 1971

11:05 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Key Circle Hospice  
1214 Eutaw Place  
Baltimore, Maryland 212174. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES  NO 

E. STREET AND NUMBER

611 St. Dunstans Road

5. SEX

F

W

6. RACE

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

8. DATE OF BIRTH

1/20/1892

9. AGE (in years  
last birthday)

79

If Under 1 Yr.  
Months Days

Hours

If Under 24 Hrs.  
Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Christolf Hucke

14. MOTHER'S MAIDEN NAME

15. Was Decoosed Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-48-7568

17. INFORMANT

Mr. Edward Lemke, Jr. 611 St. Dunstans Rd.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATHAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Deep thrombophlebitis right leg

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute pulmonary embolism

hours

(B) DUE TO, OR AS A CONSEQUENCE OF:

(c) Fracture right femur

months

CVA with residual paralysis

MEDICAL CERTIFICATION

19A. DATE OF OPERATION  
6/7119B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Fracture Femur

20A. AUTOPSY? (Yes or No)  
No20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF  
DEATH (Notify medical examiner) ---21B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?  
*Nursing Home* *by Nurse*

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
(APPROX) 6-20-71 521E. INJURY OCCURRED  
While At Work  -- Not While  
At Work 21F. HOW DID INJURY OCCUR?  
*Fall*22. I certify that (1) (this hospital) attended the deceased from July 21 1970 to December 29 1971  
that (1) (we) last saw the deceased alive on Dec. 29 1971 and that [In my] (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)23B. DATE SIGNED  
1/18/7223D. ADDRESS  
5550 Baltimore National Pike 2122824A. BURIAL CREMATION,  
REMOVAL (Specify)  
Burial24B. DATE  
1-3-7224C. NAME OF CEMETERY OR CREMATORIUM  
Mt. Carmel24D. LOCATION  
Balto.1. City, town, or county  
Md.

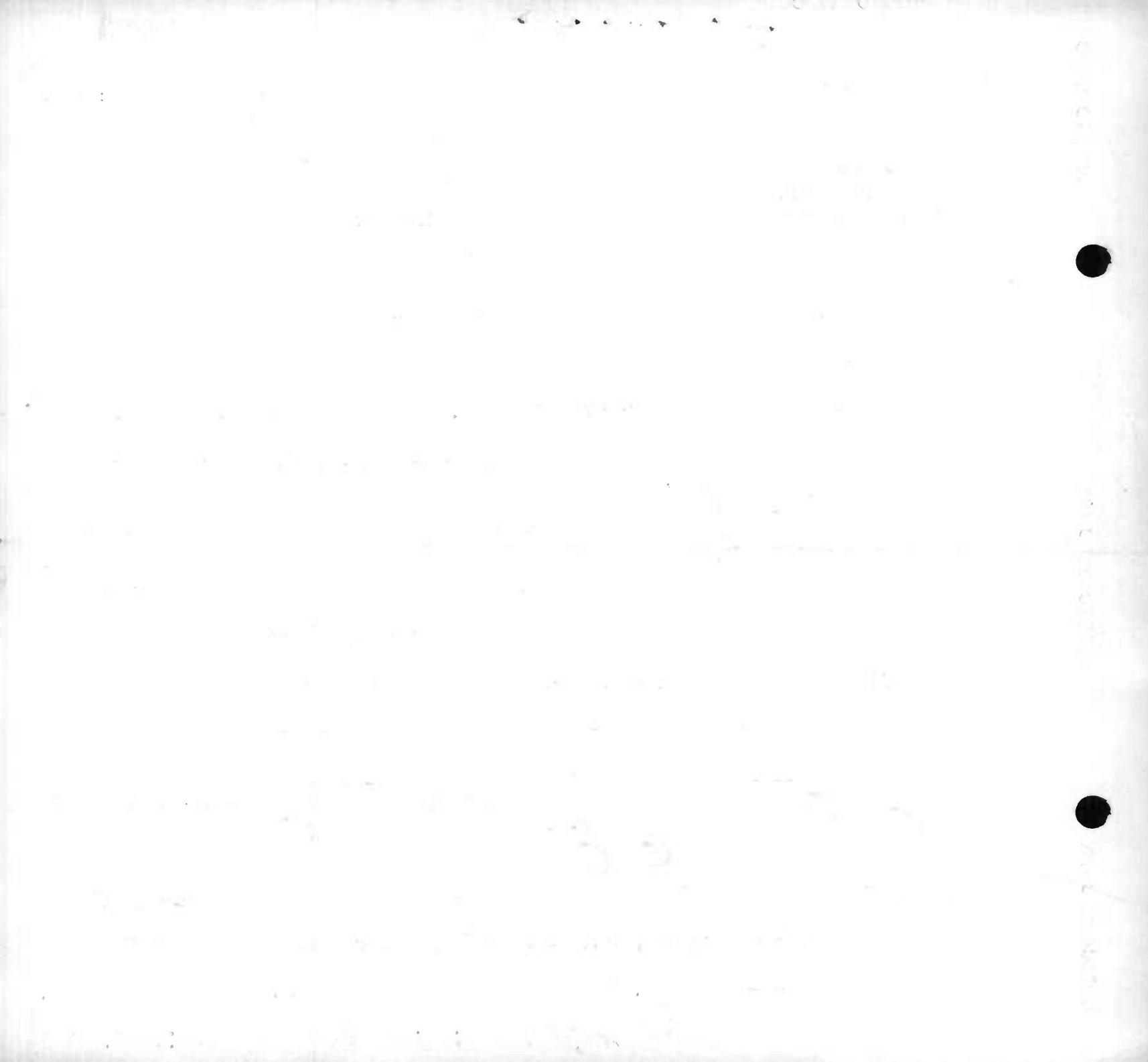
1State)

ADDRESS

H. W. Jenkins &amp; Sons Co., Md. 21212

25A. DATE REG'D. BY HEALTH DEPT.  
JAN 18 197225B. NAME OF REGISTRAR  
Robert E. Barber, M.D.

VS 150-REV. 1/1/68



H-322

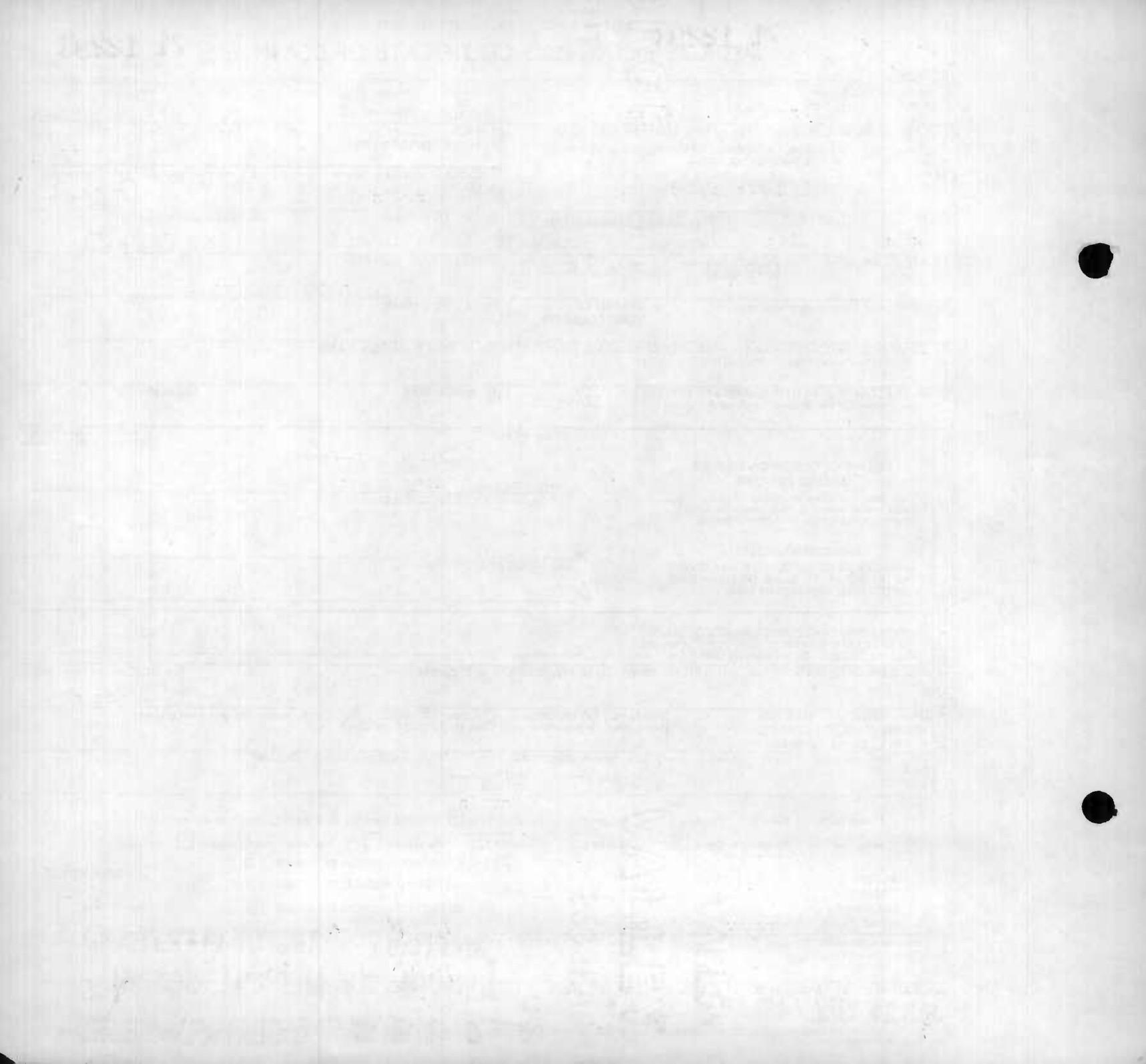
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12293

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input checked="" type="checkbox"/>	Month	Day	Year	Hour	
Raymond S. Hodges		<input type="checkbox"/>	<input type="checkbox"/>	12	21	71	11:35 A.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour		
811 E. Baltimore St.		<input type="checkbox"/>	<input type="checkbox"/>	12	21	71	11:35 A.M.		
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE		B. COUNTY		302					
Maryland									
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male		White				Baltimore		<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
9. DATE OF BIRTH		10. AGE (In years last birthday)		If Under 1 Yr. <input type="checkbox"/> Under 24 Hrs. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		E. STREET AND NUMBER		F. ADDRESS	
64						811 E. Baltimore Street			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
MEDICAL CERTIFICATION		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____									
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)	
								Partial	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT m, WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23.		Partial I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 12-21-71	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORIUM		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JAN 25 1972 Robert E. Kelley, M.D.									
VS 151-REV. 1/1/68									



M-240

71 12294

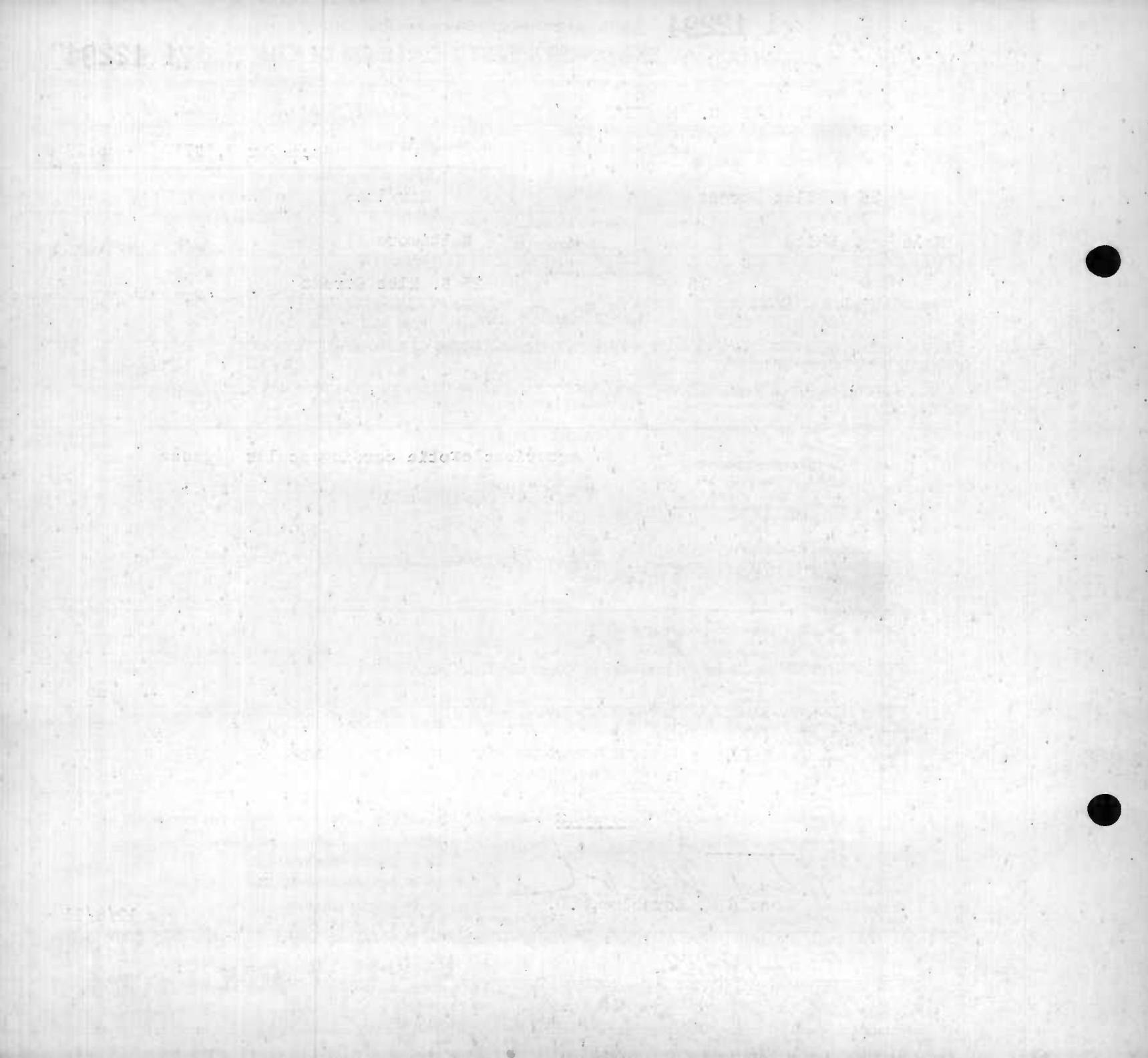
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 12294

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		CHARLES C. MESKILL		2. DATE OF DEATH	Known <input type="checkbox"/> Month	Doy	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Estimated <input type="checkbox"/>	M.			
OO 25 E. 21st Street				3. DATE PRONOUNCED DEAD	Month	Doy	Year	Hour
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	December 7, 1971		6:15 P.M.			
Male	White	C. CITY OR TOWN	Maryland		Baltimore		D. INSIDE CITY LIMITS?	
9. DATE OF BIRTH		10. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER	1206		YES <input type="checkbox"/>	NO <input type="checkbox"/>
73				25 E. 21st Street				
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		
19. 4124				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic cardiovascular disease				
		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:				
				(C)				
20A. MEDICAL CERTIFICATION		20B. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21. AUTOPSY? (Yes or No)				
		20C. DATE OF OPERATION		20D. CONDITION FOR WHICH OPERATION WAS PERFORMED		no		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.				12/8/71		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORIUM		24D. LOCATION (City, State, County, Zip Code)		
		1-18-72						
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		
JAN 25 1972		V. Kornblum, M.D.						
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE BCHD								



1  
71 12295

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12295

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARD J. GRENALE

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
  
Maryland General Hospital

(DOA)

6. SEX

Male

7. RACE

White

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

9. DATE OF BIRTH

10. AGE (In years  
less birthday)  
66If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHE8910X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE Carbon monoxide poisoning  
DUE TO, OR AS A CONSEQUENCE OF:(B) Conflagration  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
Yes22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

840 N. Eutaw Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12-11-71

22E. INJURY OCCURRED

WHILE AT WORK NOT WHILE AT WORK m. 

22F. HOW DID INJURY OCCUR?

Subject found on second floor of  
burning building

23.

I certify that I held on Inquiry  Inspection  Autopsy resulted from: Natural causes  Accident  Suicide Homicide  Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

DATE SIGNED

RECEIVED BY

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

RECEIVED BY

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

RECEIVED BY

EXAMINER'S  
NAME (Type)

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EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

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Charles S. Springate, M.D.

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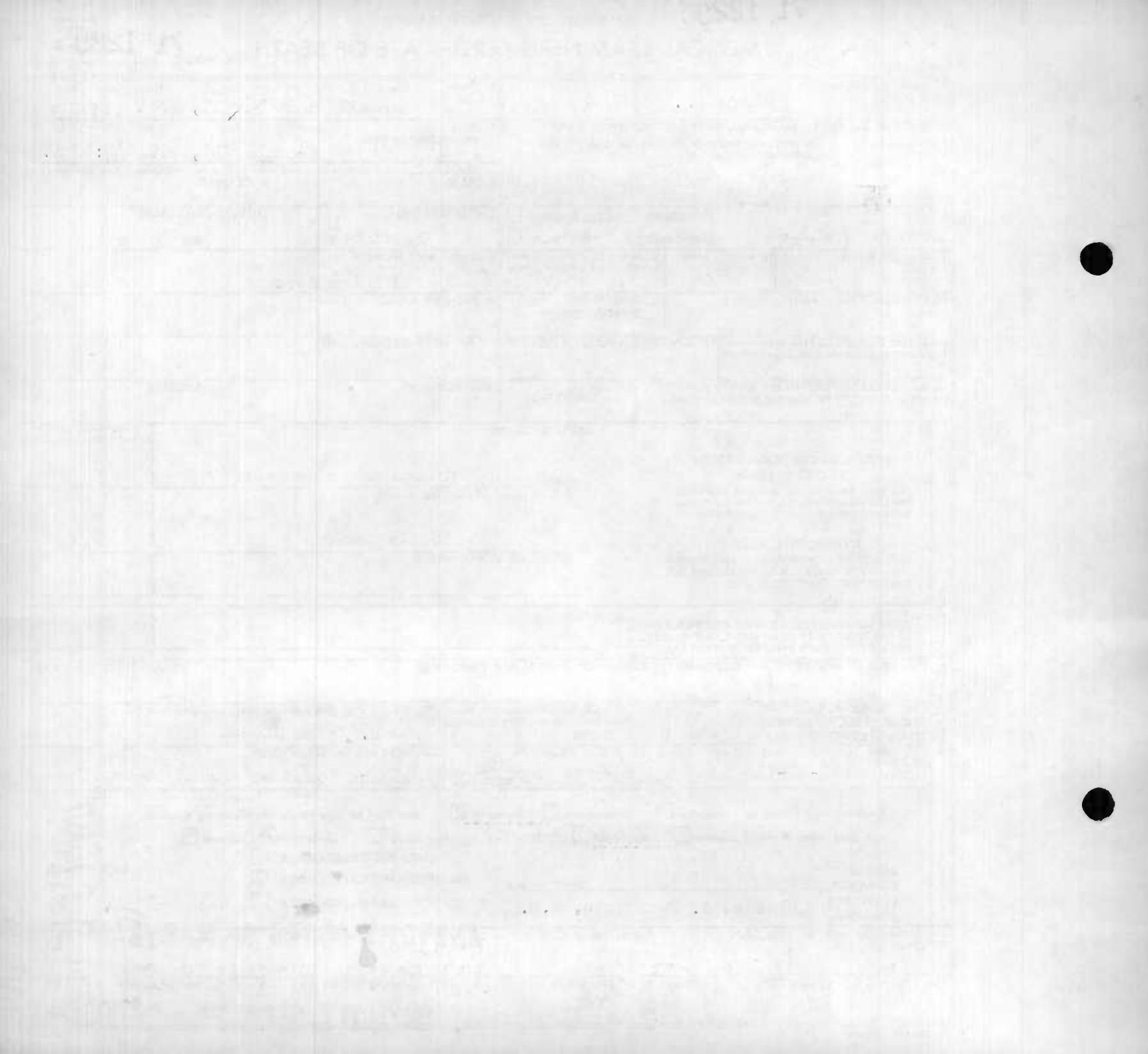
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

RECEIVED BY

EXAMINER'S  
NAME (Type)

Charles S. Spring



H-125

71 12296

BALTIMORE CITY HEALTH DEPARTMENT

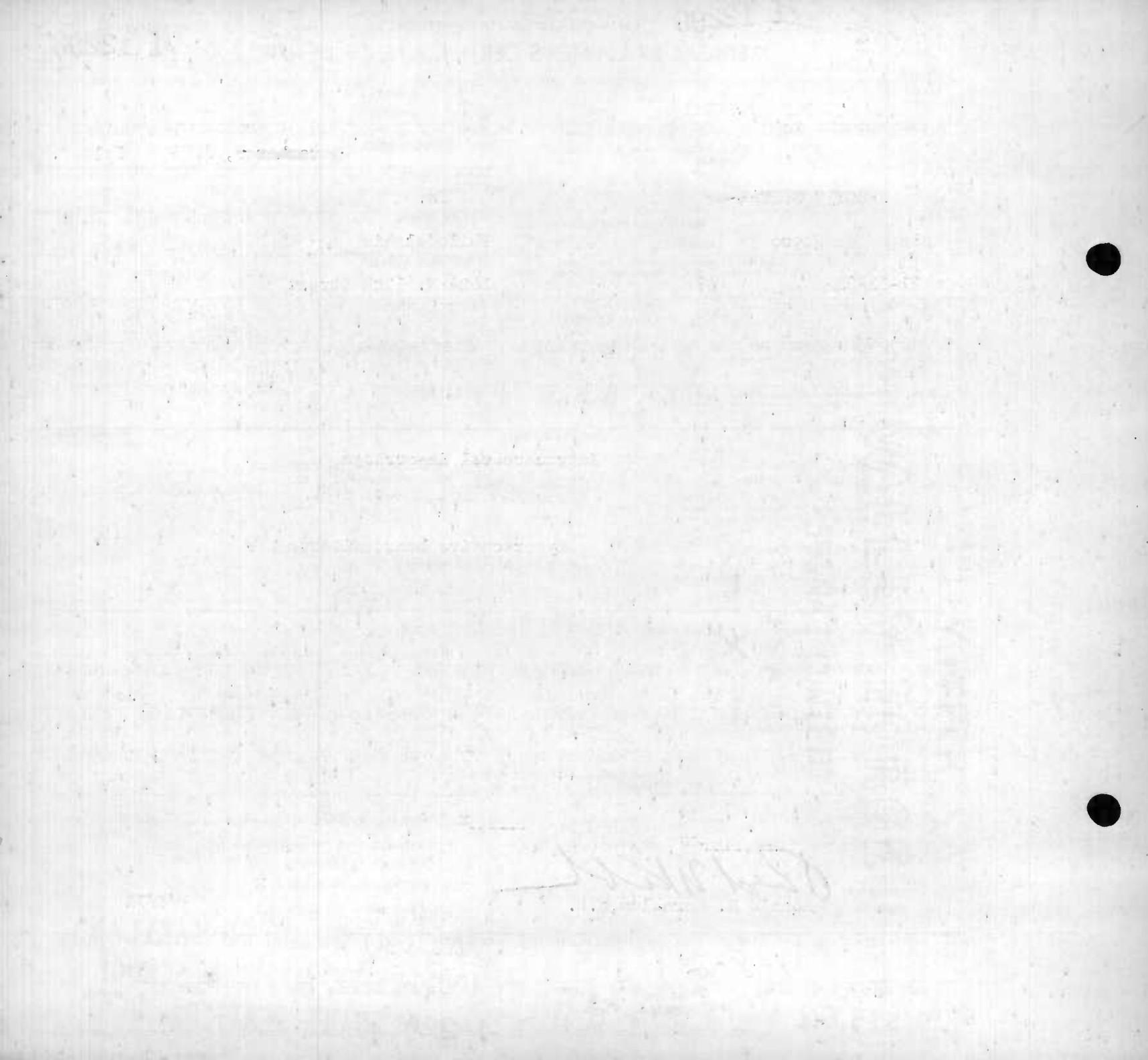
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12296

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM HOPKINS			2. DATE OF DEATH Known <input type="checkbox"/> Month _____ Day _____ Year _____ Hour _____ Estimated <input type="checkbox"/>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  MERCY HOSPITAL			3. DATE PRONOUNCED DEAD Month _____ Day _____ Year _____ Hour _____ November 9, 1971 3:18 P. M.
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Philadelphia
9. DATE OF BIRTH 11-13-23		10. AGE (In years lost birthday) 47	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	E. STREET AND NUMBER 2024 N. 12th Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS
19. <i>402 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CAUSE OF DEATH Intracerebral Hemorrhage  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) Hypertensive heart disease DUE TO, OR AS A CONSEQUENCE OF:  (C)
20A. DATE OF OPERATION <i>2</i>			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (In Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum, M.D.</i> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>1-18-72</i>	24C. NAME OF CEMETERY or Crematory ADDRESS City, State & County (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1972</i>		25B. NAME OF REGISTRAR <i>Robert S. Tolson, M.D.</i>	
26. ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL ADDRESS 2 MORTUARY SERVICE - BCHA			



71 12297

BALTIMORE CITY HEALTH DEPARTMENT

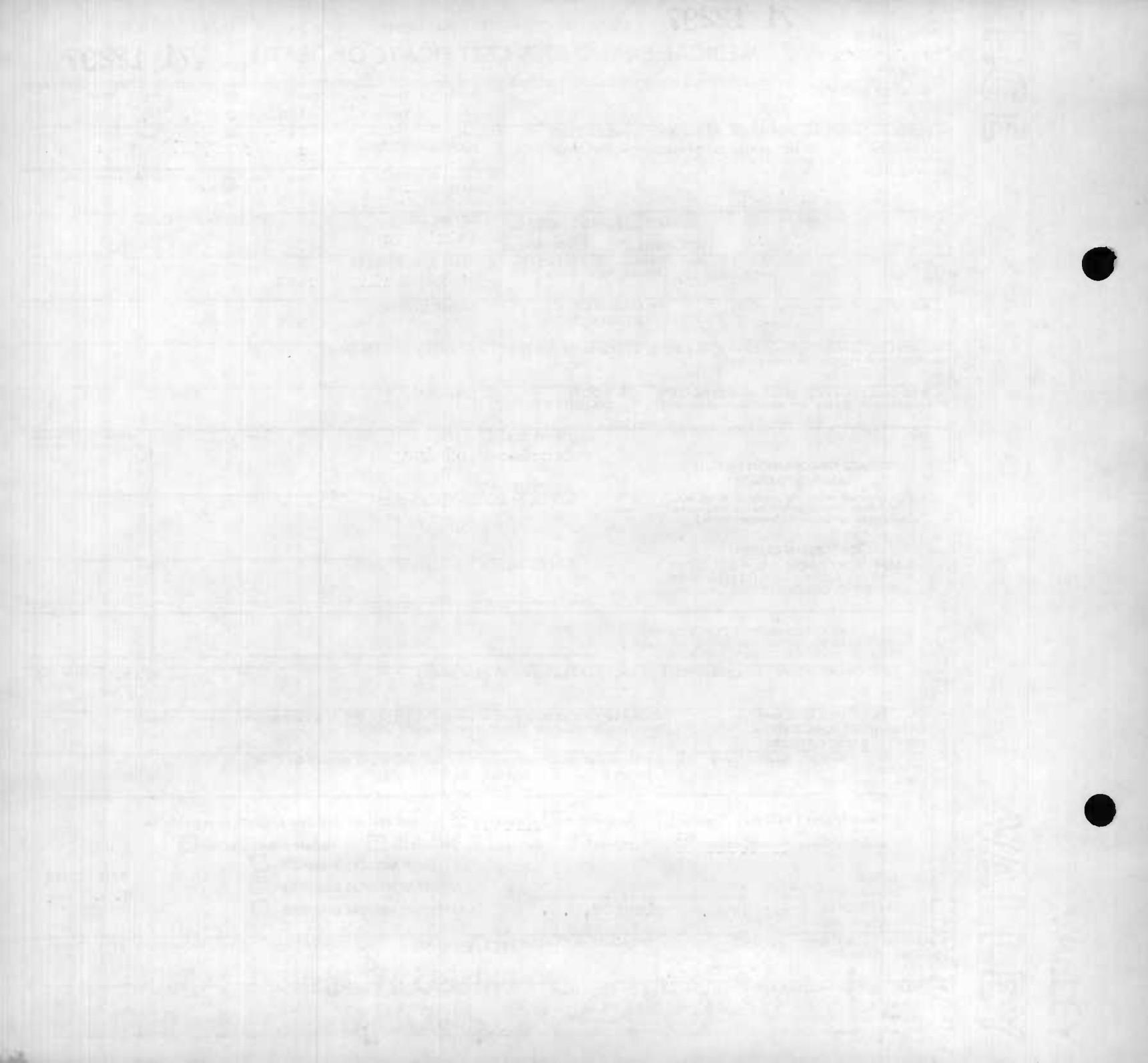
BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12297

1. NAME OF DECEASED (Type or Print) AJAY WARD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month December Estimated <input type="checkbox"/> Day 23, 1971 Year 1971 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION  UNIVERSITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month December Day 23, 1971 Year 1971 Hour 8:10 A.M. M.	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years last birthday) 49	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
19. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carcinoma of lung  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT m. <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 1-18-72	24C. NAME OF CEMETERY or Crematory	DISPOSITION (Check one or more) (State)
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972	25B. NAME OF REGISTRAR <i>Robert E. Valley, Jr.</i>	ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL ESCAPE FUNERAL DIRECTOR ADDRESS	
MORTUARY SERVICE - BCHD			



S-421

71 12298 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12298

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEON SALISBURY

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

311 S. Sharp St.

6. SEX

male

7. RACE

negro

8. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.18. INFORMANT  
ADDRESS19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the cause of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING  OR CONTRIB-  
UTING  CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK  NOT WHILE  
AT WORK 

22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry  Inspection  Autopsy  and that on this basis, death in my opinionresulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER 

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER 

12-27-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY

24D. LOCATION (City, Town or Street) (State)

ANATOMY BOARD OF MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

UNIVERSITY MEDICAL SCHOOL

ADDRESS

MORTUARY SERVICE - BCHD

1-27-1972 - Letter from - Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

J-525 71 12299

BALTIMORE CITY HEALTH DEPARTMENT

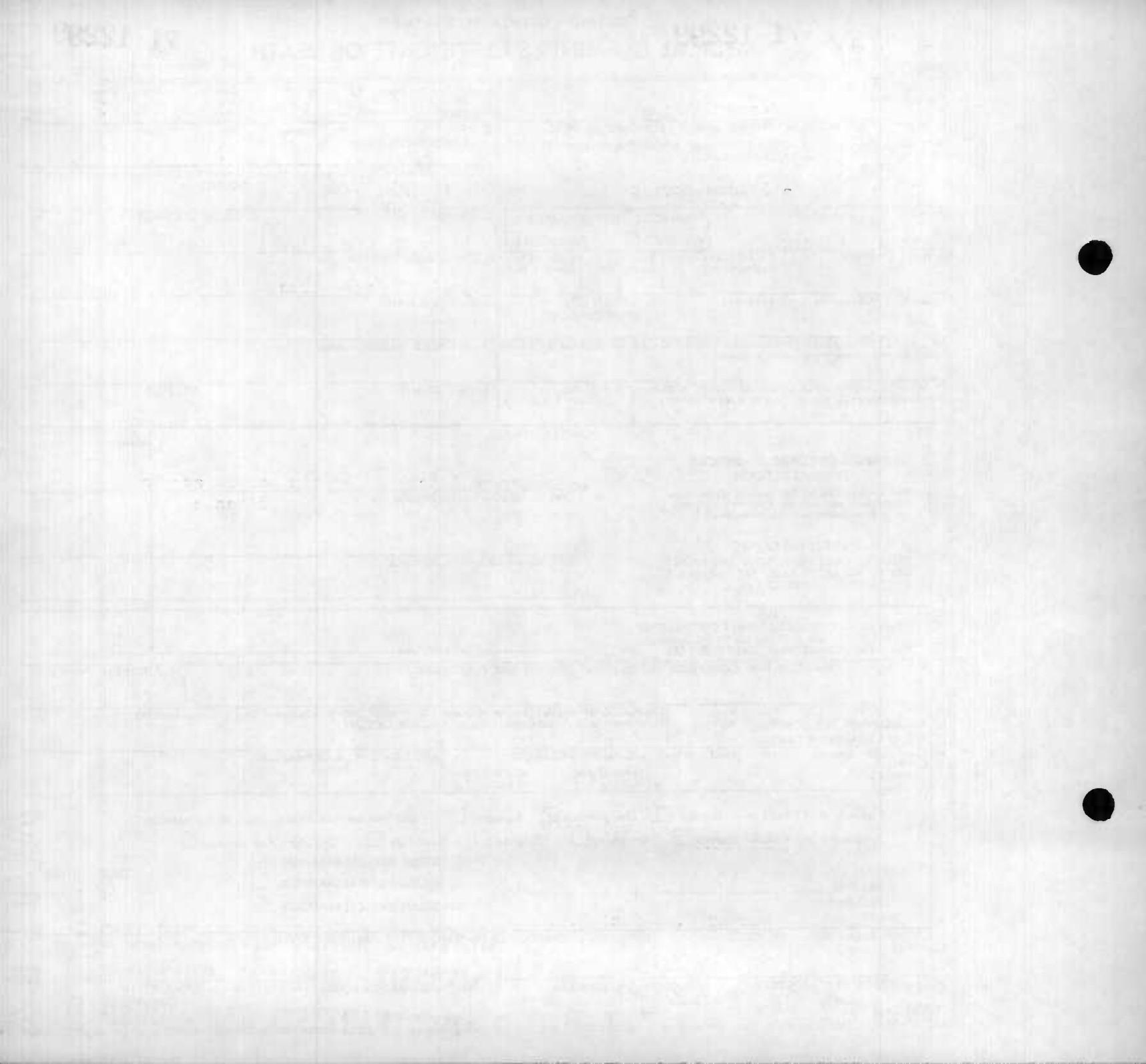
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 12299

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Edward Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Estimated <input type="checkbox"/> Day 13 Year 71	Hour 3:26 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		1023 Race Street		3. DATE PRONOUNCED DEAD Month 12 Day 13 Year 71	Hour 3:26 P.M.
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		
9. DATE OF BIRTH		10. AGE (In years lost birthday) 60?	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1023 Race Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT	ADDRESS
19. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/>      resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>      Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>      M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>      EXAMINER'S ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>      NAME (Type) Werner U. Spitz, M.D.</p>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-21-72</i>	24C. NAME OF CEMETERY COLUMBIAN	24D. LOCATION (City & State) ANATOMY BOARD OF MARYLAND (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1972</b>		25B. NAME OF REGISTRAR <i>Robert E. Jaeger, Jr.</i>		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



BIRTH NO.

71 12300 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 12300

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input checked="" type="checkbox"/>	Month	Day	Year	Hour
Leroy Buckley		Estimated <input type="checkbox"/>	12	25	71			M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour	A.M. / P.M.
709 W. Fayette St.		12	25	71	11:30	a.m.	402	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
male	Negro				Balto.		YES <input type="checkbox"/>	NO <input type="checkbox"/>
9. DATE OF BIRTH	10. AGE (In years last birthday)	70 ?	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER		709 W. Fayette St.	
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		
19. MEDICAL CERTIFICATION		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		Arteriosclerotic cardiovascular disease						
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.4</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C)						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
<p>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 12/26/71</p> <p>ACTUAL SIGNATURE <i>Sylvester M. Peter Lipkovic, M.D.</i> EXAMINER'S NAME (Type)</p>								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-25-72		24C. NAME OF CEMETERY or ANATOMY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1972		25B. NAME OF REGISTRAR 9700		25C. FUNERAL DIRECTOR		ADDRESS		
<b>ANATOMY BOARD OF MARYLAND</b> <b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCHD</b>								

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BALTIMORE CITY HEALTH DEPARTMENT

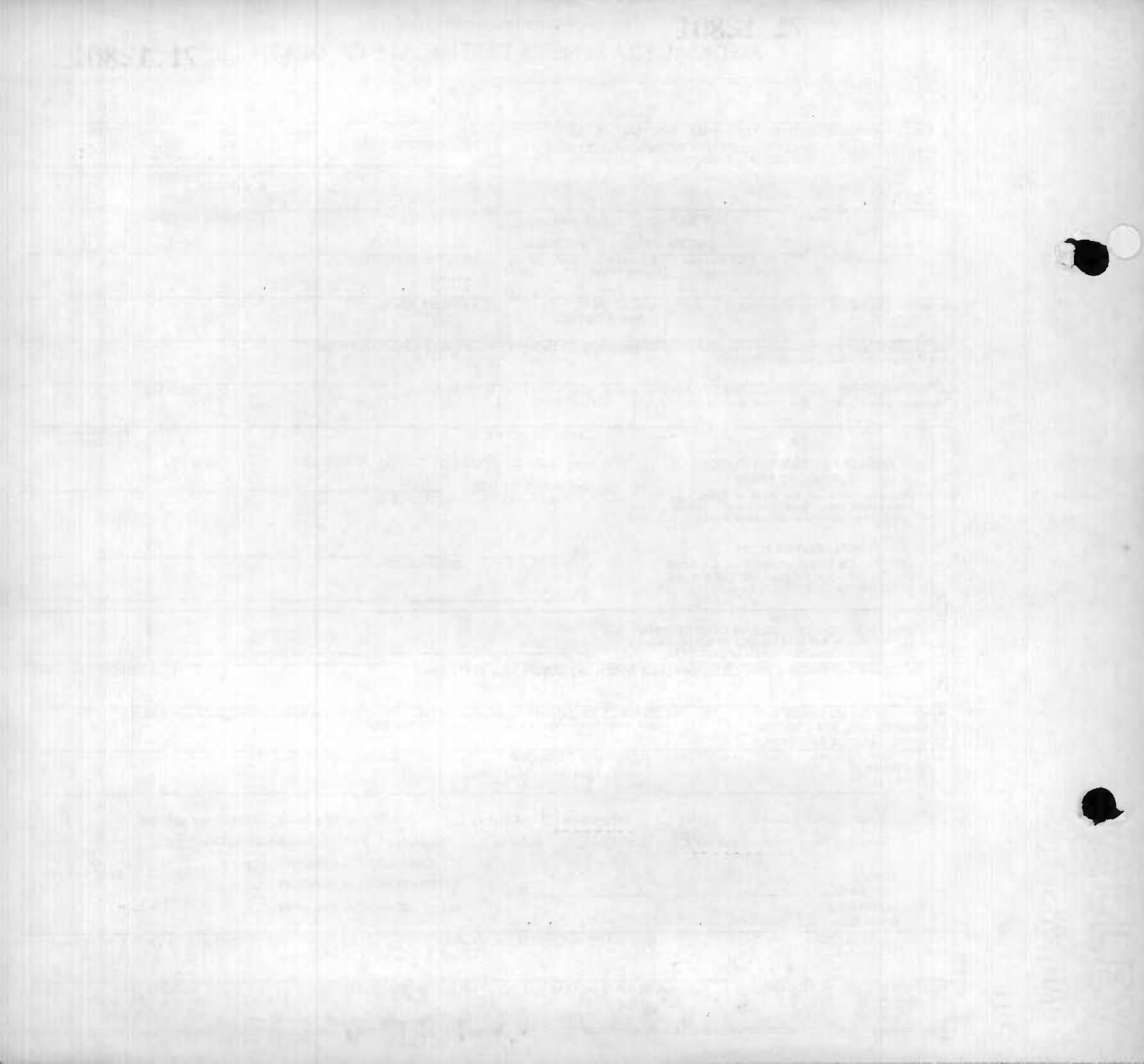
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71-12301  
71-12801

## BIRTH NO.

1. NAME OF DECEASED (Type or Print)		LOUISE BROWN		2. DATE OF DEATH	Known <input type="checkbox"/> Month	Day	Year	Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		1305 N. Stricker St.		Estimated <input type="checkbox"/>	M.				
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3. DATE PRONOUNCED DEAD Month Day Year Hour November 12, 1971 12:30 P.M.						
Female	Negro	9. DATE OF BIRTH	10. AGE (In years lost birthday) 86	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1305 N. Stricker St.					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
MEDICAL CERTIFICATION	19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:								
	(B) DUE TO, OR AS A CONSEQUENCE OF:								
	(C) _____								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
				No					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23.		<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 11-13-71</p>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-1-72	24C. NAME OF CEMETERY or CREMATORIUM		24D. LOCATION (City, State, County)		ANATOMY BOARD OF MARYLAND UNIVERSITY OF MEDICAL SCHOOL MORTUARY SERVICE - BCMD		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR FEB 2 1972 Robert J. Barber, Jr.	25C. FUNERAL DIRECTOR		ADDRESS				



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12802		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71-12302	
1. NAME OF DECEASED (Type or Print)		71-12302		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 10 A.M. 12-25-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Baithome		B. COUNTY Home			
90 Kenison Nursing Home 2932 Arundel Ave		C. CITY OR TOWN		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-20-1898	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 93		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Jerry Fowler Unknown		14. MOTHER'S MAIDEN NAME Laura Morris				12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. MA715715		17. INFORMANT Mrs. Kennedy - in charge.		ADDRESS 2922 Branch Ave	
18. I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many months	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Hypertensive C.V. Disease DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) possible Septicemia DUE TO, OR AS A CONSEQUENCE OF:				many months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)				many months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1971 to Dec. 25, 1971 that (I) (we) last saw the deceased alive on Dec. 25, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED Jan. 25, 1972					
Frank N. Ogden, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
FRANK N. OGDEN, M.D.		2701 N. Calvert St. Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-30-71		24C. NAME OF CEMETERY OR CREMATOR Y Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) Westport (Baltimore) Md. (State)	
Burial							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson, M.D.		25C. FUNERAL DIRECTOR Joseph G. Price		ADDRESS 2222 W. North Ave.	
FEB 15 1972							
VS 150-REV. 1/1/68							



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-534		12303	BALTIMORE CITY HEALTH DEPARTMENT		X ✓ REG. NO. 71 12303 12303
BIRTH NO. 71-20634		71 12803	CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		Baby Girl Bentley		2. DATE AND HOUR OF DEATH 12-12-71 13:50PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE & COUNTY			
42 Sinai Hospital of Baltimore, Inc.		Maryland Baltimore			
5. SEX girl		6. RACE C		5. SEX girl	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) 2 days	
13. FATHER'S NAME Homer Bentley		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Patricia Lengly	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT		ADDRESS	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.		(A) IMMEDIATE CAUSE Immaturity DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		(D) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-10-71 19 to 12-12 1971 that (I) (we) last saw the deceased alive on 12-12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sompong Wattanasakul</i>		DEGREE MD		23B. DATE SIGNED 12-12-71	
23C. PHYSICIAN'S NAME (Type) Sompong Wattanasakul		23D. ADDRESS Sinai Hospital of Baltimore, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) DISPOSAL		24C. NAME OF CEMETERY or CREMATORIAL SINAI HOSPITAL		24D. LOCATION (City, town, or county) BALTO, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1972		25B. NAME OF REGISTRAR Robert S. [Signature]		25C. FUNERAL DIRECTOR 12 HOSPITAL DISPOSAL	
VS 150-REV. 1/1/68					

Hospital gave zip 7521236.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 12304		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		71 12304	
1. NAME OF DECEASED (Type or Print)		71-19479		CERTIFICATE OF DEATH				4	
Female		Green		2. DATE AND HOUR OF DEATH		November 19, 1971   11:36AM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FEMALE (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	B. COUNTY	Maryland			
42 Sinai Hospital of Baltimore, Inc.				C. CITY OR TOWN		Baltimore		D. INSIDE CITY LIMITS?	
				E. STREET AND NUMBER		3732 Dolfield Avenue		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.
Female	Negro			11/19/71	Newborn				4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None		None		Maryland		United States			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Clarence Howard		Brenda Green							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		NO		none					
18. CAUSE OF DEATH									
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small>									
<small>(A) IMMEDIATE CAUSE Immaturity DUE TO, OR AS A CONSEQUENCE OF:</small>									
<small>(B) DUE TO, OR AS A CONSEQUENCE OF:</small>									
<small>(C) _____</small>									
<b>II</b> <small>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</small>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED  While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 		23B. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		Sinai Hospital of Baltimore, Inc.					
Dr. Albert Gabbay									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIAL		24D. LOCATION		(City, town, or county) (State)	
DISPOSAL		NOV. 1971		SINAI HOSPITAL		BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 14 1972		John E. Tolson, Jr.		HOSPITAL DISPOSAL					
VS 150-REV. 1/1/68									

200

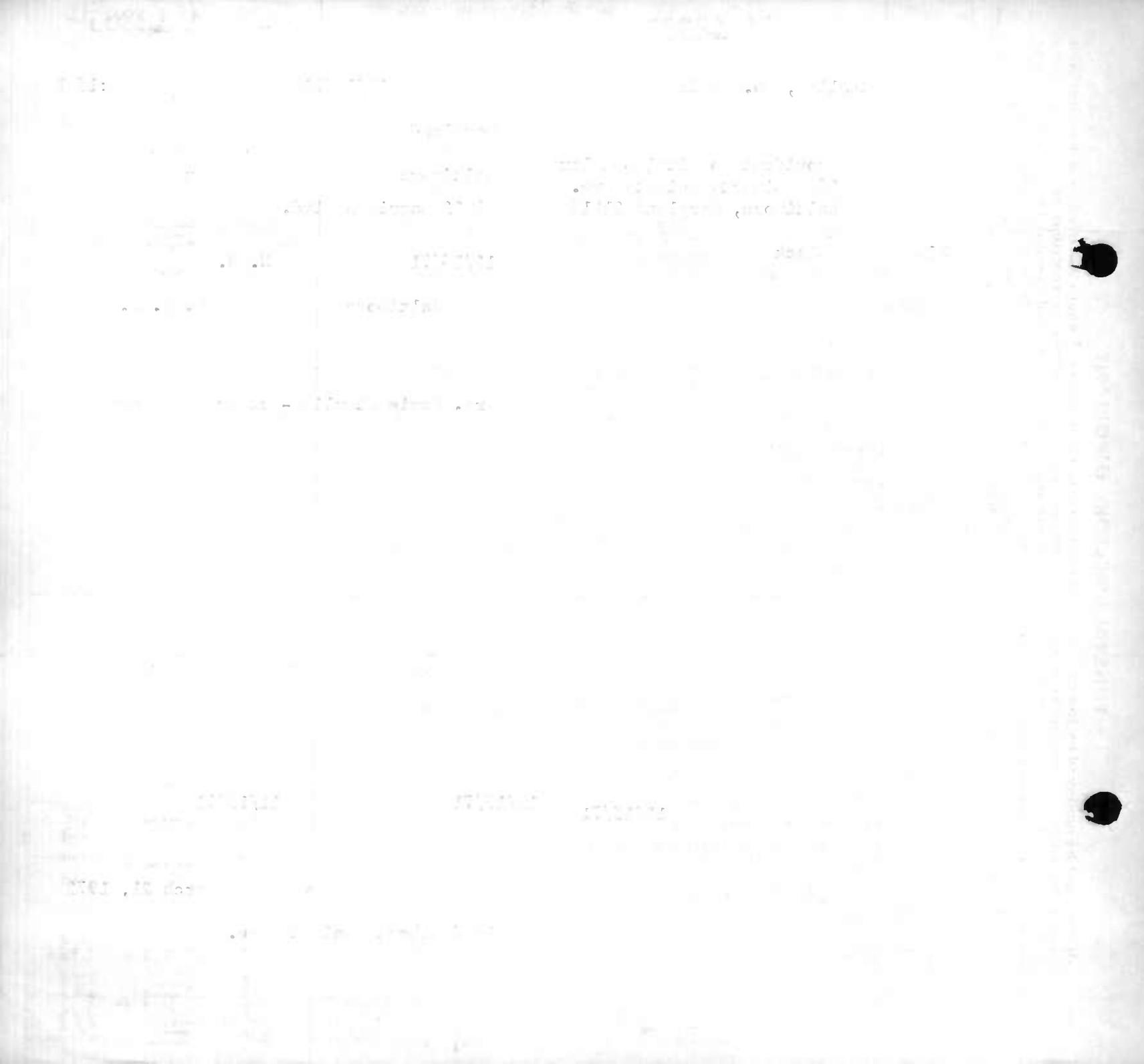
200

and the new Almond

## **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

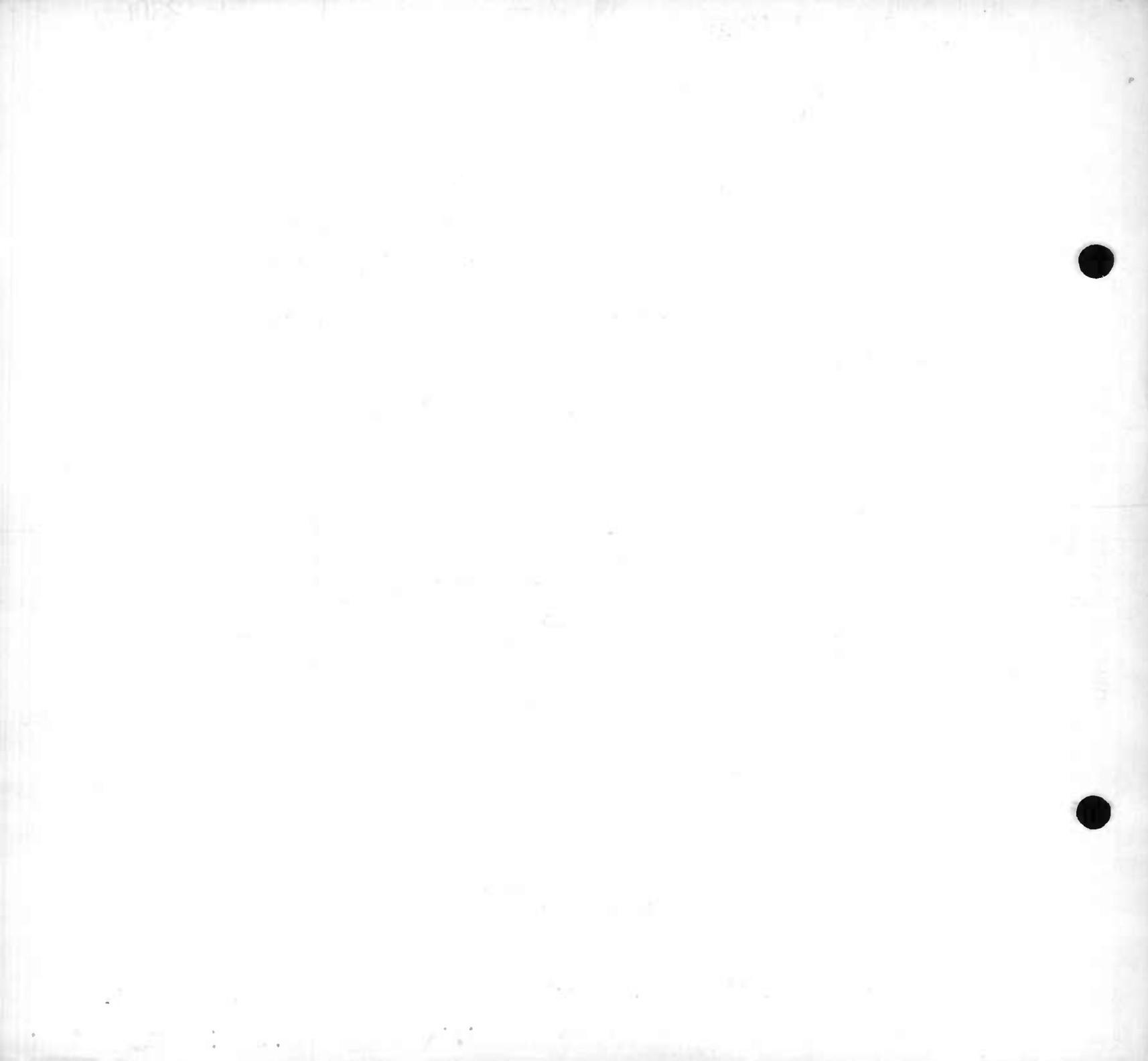
Baltimore City Health Department				REG. NO. 71 12305	
1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH			
Sterling, Bo. Esmie		2. DATE AND HOUR OF DEATH		12/15/71 8:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  39		A. STATE Maryland 1538 B. COUNTY			
(If not in hospital or institution, give street address or location)  Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/15/71		9. AGE (in years lost birthday) N. B.		10. If Under 1 Yr. Months Days 11 Under 24 Hrs. Min. 20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES		17. INFORMANT ADDRESS Mrs. Esmie Sterling-Mother Same			
CAUSE OF DEATH  (A) IMMEDIATE CAUSE Emma Tunit/ DUE TO, OR AS A CONSEQUENCE OF:  (B) PREMATURE DELIVERY DUE TO, OR AS A CONSEQUENCE OF:  (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/15/71 19 12/15/71 19 that (I) (we) last saw the deceased alive on 12/15/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED March 21, 1972		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS 2600 Liberty Heights Ave.		
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORIUM	24D. LOCATION	(City, town, or county) (State)	
DISPOSAL	3-1971	PROVIDENT HOSPITAL	BALTO. Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
MAR 28 1972 Robert E. Jolley, Jr.		HOSPITAL DISPOSAL			
VS. 150-REV. 1/1/68					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520		7171230608	BALTIMORE CITY HEALTH DEPARTMENT	REG. NO. 7171230608
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MARGARET M. LEMKE		29 Dec. 1971 11:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  Key Circle Hospice		A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 611 St. Dunstans Rd.		
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/92	9. AGE (in years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMESWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME CHRISTOLF HUKKE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 317448-7588		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT ? EDWARD LEMKE, JR. (SAME)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours		
(A) IMMEDIATE CAUSE Ante pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If not medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home - House Key Circle		21C. WHERE DID INJURY OCCUR? (If in Belimere City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) (APPROX) 6-20-71?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell while walking
22. I certify that (I) (We) attended the deceased from shot-(I) (We) last saw the deceased alive on Dec. 29 1971		to July 21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.		
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/30/71
23C. PHYSICIAN'S NAME (Type) DIONISIO GARCIA JR.		23D. ADDRESS 5550 Baltimore Park Place 21228		
24A. BURIAL/CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/72		24C. NAME OF CEMETERY OR CREMATOR Y Mt. Carmel
24D. LOCATION Baltimore, Md.		(City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972		25B. NAME OF REGISTRAR Sidney Thompson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.
VS 150-REV. 1/1/68		ADDRESS BALTO., MD. 21212		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-534 BIRTH NO. 71-20434		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 12306	
1. NAME OF DECEASED (Type or Print) Baby Girl Bentley		2. DATE AND HOUR OF DEATH 12-12-71		3:50 p.m.	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  Sinai Hospital of Baltimore, Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY BALTO 5300			
5. SEX Female C 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-71		9. AGE (in years lost birthday) 2 days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Homer Bentley		14. MOTHER'S MAIDEN NAME Patricia Lengly		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT void	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH  Immaturity DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES Diseases or conditions, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: See D.C. 71-12303		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?  (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?  void	
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on		12-10-71		19 to 12-12-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Samsong Wattanasakul		M.D. DEGREE		23B. DATE SIGNED 12-12-71	
23C. PHYSICIAN'S NAME (Type) Samsong Wattanasakul, M.D.				23D. ADDRESS Sinai Hospital of Baltimore, Inc.	
24A. BURIAL CREMATION, REMOVAL (Specify) 44-72		24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 44A LOCATION TOWNSHIP, CITY, OR COUNTY, STATE		24D. LOCATION TOWNSHIP, CITY, OR COUNTY, STATE	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Reba J. [Signature]		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL ANATOMY BOARD OF MARYLAND MORTUARY SERVICE - BCHD	
VS 150-REV. 1/1/68					

